# Psycho-Social Barriers to Accessing Sexual and Reproductive Health and Rights Services among Young Women with Disabilities at National Council of Disabled Persons of Zimbabwe

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## ABSTRACT

This study investigated the psycho-social challenges encountered by young women with disabilities in accessing sexual and reproductive health and rights (SRHR) services and information at the National Council of Disabled Persons of Zimbabwe (NCDPZ). The research was prompted by the increasing prevalence of SRHR violations against this population, rooted in interconnected barriers operating at various socio-ecological levels. A purposive sample of 52 young women with diverse disabilities was drawn from NCDPZ for participation. The study aimed to identify the key psycho-social barriers affecting SRHR access and to explicitly analyze how these challenges are distributed across Bronfenbrenner's ecological model, namely, the microsystem, mesosystem, exosystem, and macrosystem.

Using a qualitative design and semi-structured interviews, the research identified major barriers including: fear of discrimination and stigma (microsystem - individual and interpersonal), exclusion from local SRHR programming (mesosystem - community and institutional interactions), limited dissemination of accessible SRHR information (exosystem - organizational and media structures), and systemic marginalization reinforced by cultural beliefs and insufficient policy implementation (macrosystem - societal and legislative frameworks). These findings show that the most pervasive factor was a widespread lack of SRHR awareness across all ecological levels, affecting both persons with disabilities and duty bearers.

The study emphasizes the importance of multi-level interventions,ranging from family and peer education to structural reforms and national policy advocacy, to ensure disability-inclusive SRHR service delivery. These insights align with Zimbabwe's National Development Strategy 1 and reinforce the global Sustainable Development Goals (SDGs) mandate to leave no one behind.

## BACKGROUND

Young women with disabilities represent one of the most marginalized and excluded groups globally. They experience deep inequalities across social, economic, and civic spheres—facing negative societal attitudes, discrimination, violence, and limited access to essential services such as education, employment, and healthcare. These challenges are compounded by widespread misconceptions, including harmful beliefs that portray them as asexual or incapable of decision-making, particularly concerning their sexual and reproductive health and rights (SRHR).

In Zimbabwe, where approximately 9.2% of the population lives with a disability and over half the population are women, the intersection of gender and disability intensifies the barriers young women face. Many are excluded from economic opportunities and are at heightened risk of sexual violence, early and forced marriage, unintended pregnancies, and HIV infection. Traditional and religious norms often perpetuate stigma, while systemic neglect in healthcare settings further limits their access to accurate SRHR information and services.

According to the World Health Organization, persons with disabilities comprise about 15% of the global population, with 75% of women with disabilities living in developing countries. In Zimbabwe, statistics from the Zimbabwe National Statistics Agency (2014) show that one in three women aged 20 to 49 were married before turning 18, with 4% married before age 15—factors linked to adverse health outcomes such as maternal mortality, particularly among girls with disabilities.

Young women with disabilities in cities like Gweru continue to experience exclusion and discrimination within healthcare systems. Health professionals may dismiss their needs, limit their autonomy, or withhold care—leading to psycho-social distress and disengagement from services such as HIV treatment. Research shows that legal restrictions on abortion and lack of comprehensive sexuality education contribute to unsafe practices, with unsafe abortions accounting for around 20% of maternal deaths—many involving adolescents with disabilities.

Although Zimbabwe ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2013, significant gaps remain in the implementation of inclusive policies and services. Cultural stigma, economic hardship, and weak institutional accountability persist, denying young women with disabilities the right to make informed choices about their bodies and futures.

This study focuses on the psycho-social dimensions of SRHR access among young women with disabilities in Gweru, acknowledging their complex, intersecting experiences shaped by gender, disability, and socio-economic status. It aims to explore how these factors influence their engagement with health services, and what strategies might mitigate the barriers they face.

## Statement Of The Problem

In the 21st century, access to sexual and reproductive health (SRH) services is recognized as a fundamental human right. However, this right remains unattainable for many, particularly in developing regions such as Africa, where competing socio-economic priorities hinder the delivery of comprehensive SRH care (Mprah, 2013; Glasier et al., 2006). According to the World Health Organization (2009), women with disabilities represent one of the most marginalized and underserved groups in accessing SRH services. This exclusion is largely perpetuated by deep-rooted societal stigma and negative perceptions surrounding disability, which have led to persistent suffering and systemic neglect of the SRH needs of women with disabilities.

Despite global affirmations that SRH services are universal rights regardless of physical appearance or ability, limited focus has been placed on the specific psycho-social challenges faced by young women with disabilities in accessing these services. These challenges—such as discrimination, social isolation, and internalized stigma—not only hinder access but also heighten their vulnerability to violations of their SRH rights. Many young women with disabilities experience sexual abuse and exploitation, largely due to their lack of access to appropriate SRH information and services. Addressing these issues requires a targeted and inclusive approach that recognizes and responds to the unique psycho-social barriers confronting this marginalized group.

## Purpose Of The Study

The primary aim of this study is to examine the psycho-social challenges faced by young women with disabilities in accessing sexual and reproductive health and rights (SRHR) services and information. The research seeks to identify these barriers and propose practical, evidence-based interventions to enhance access and promote the inclusion of young women with disabilities in SRHR initiatives

## Research Objectives

1. To identify the common psycho-social challenges encountered by young women with disabilities in accessing sexual and reproductive health and rights (SRHR) services and information.

2. To examine how these psycho-social challenges are shaped and influenced across various socio-ecological levels.

## Research Questions

1. What psychological challenges hinder young women with disabilities from accessing sexual and reproductive health and rights (SRHR) services and information?

2. What social barriers do young women with disabilities face in accessing SRHR services and information?

3. How do young women with disabilities perceive their access to SRHR services and information?

4. What are the perceived needs or suggested interventions by young women with disabilities and other stakeholders to alleviate these difficulties?

## LITERATURE REVIEW

### Introduction

The chapter explores literature related to psycho-social challenges faced by young women with disabilities in accessing SRHR services and information. This chapter also looks at the theoretical framework that is guiding the research and previous studies where the knowledge gap is identified.

### Sexual And Reproductive Health

Despite the fact that, aside from HIV and AIDS, sexual and reproductive illnesses are a major source of morbidity and death, the topic has not been able to get widespread provision from outside funders. Critics argue that the vision advanced at the 1994 International Conference on Population and Development (ICPD) in Cairo was overly idealistic. By focusing on broader issues such as women's empowerment and reproductive rights instead of prioritizing service delivery, the movement may have unintentionally hindered practical outcomes (Glasier et al., 2006). Moreover, in today's climate of health sector reform, funding decisions are often driven by disease burden indicators such as Disability-Adjusted Life Years (DALYs), which do not always account for the multidimensional nature of SRH, including human rights and quality of life.

The ICPD affirmed that all women, including those with disabilities, should have unimpeded access to their sexual and reproductive health rights. It emphasized the inclusion of persons with disabilities as integral to achieving universal SRH access. Despite this, access remains limited, and the interpretation of what constitutes a disability continues to vary widely, especially in rural and traditional communities where stigma persists. Many individuals with disabilities continue to face social exclusion and discrimination, reinforcing the need to align national laws with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006).

Zimbabwe is a signatory to several international frameworks, including the 1985 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the UNCRPD. Nationally, laws such as the National Disability Policy (2021) acknowledge the rights of persons with disabilities to access health services on an equal basis. These frameworks aim to eliminate discrimination and affirm sexual and reproductive health rights as fundamental human rights for all—irrespective of gender, disability, ethnicity, or socio-economic background.

Globally, approximately 15% of the population lives with a disability (WHO, 2011), with a significant proportion of women with disabilities residing in low- and middle-income countries. These women often face intersecting forms of marginalization—being disproportionately excluded from economic empowerment programs, more likely to be victims of sexual and gender-based violence, and frequently denied access to quality SRH services (Rugoho & Siziba, 2014; Rugoho & Maphosa, 2015; Shuttleworth, 2007). Negative societal and familial attitudes, discriminatory health care practices, and rigid cultural norms further limit their access to SRH services (Bath, 2008; Burgen, 2010).

The UNCRPD and the Zimbabwean Constitution both affirm the right to SRH as part of the broader spectrum of human rights. Article 23 of the UNCRPD guarantees the right to found a family, while Article 12 upholds the legal capacity of persons with disabilities to make decisions, including those relating to their health. Importantly, these protections include the right to informed consent and freedom from coerced medical interventions such as forced sterilization or abortion—practices that have historically violated the dignity and autonomy of women with disabilities. CEDAW explicitly prohibits such practices.

Zimbabwe’s 2006 National Reproductive Health Policy acknowledges SRH as essential to overall health and development, covering maternal health, family planning, and adolescent reproductive health. However, the policy offers minimal intervention for women with disabilities, primarily due to the continued perception of disability as a charitable, rather than rights-based, issue (Kabzems & Chimedza, 2002). This gap in inclusive policy and funding undermines the country's ability to address the specific needs of women with disabilities, particularly in psychosocial contexts.

While several non-governmental organizations (e.g., Leonard Cheshire Disability Zimbabwe, National Council of Disabled Persons of Zimbabwe, and the Deaf Zimbabwe Trust) are active in promoting access to SRH for women with disabilities, their efforts are largely limited to advocacy and awareness. There remains a scarcity of empirical research on the psychosocial barriers young women with disabilities face in accessing SRH services and information, limiting the development of evidence-based, targeted interventions.

## Understanding The Disability Framework

Disability encompasses a range of long-term physical, mental, intellectual, or sensory impairments that may hinder a person’s full and effective participation in society on an equal basis with others (UNCRPD, 2006). Disabilities may be visible or invisible, congenital or acquired. The modern understanding of disability emphasizes the interaction between an individual’s impairment and environmental, societal, or attitudinal barriers that collectively limit inclusion.

Acknowledging that disability is not a homogeneous group is essential in designing inclusive SRHR programs that consider both individual and structural factors. Inclusive frameworks must shift away from charity-based models to rights-based approaches that empower persons with disabilities as agents of their own health and wellbeing.

## Physical Barriers

Physical obstacles are those that hinder people with disabilities from accessing physical settings for instance, roads, structures, transit, and different indoor and outdoor amenities such as learning facilities, homes, health facilities, athletic events, and/or businesses. According to WHO (2013) and Ghroce et al. (2009), WWDs require more access to SRH services than their counterparts without disabilities. Their condition also makes them more vulnerable to sexual assault (Rugoho & Maphosa 2015). Women with disabilities experience difficulties in receiving SRHR services due to inaccessible structures at health institutions. In most impoverished nations, district clinics and community clinics have inaccessible infrastructure. As a result, ladies in wheelchairs would require assistance in accessing these services.

## Attitudinal Barriers

The most difficult obstacle in the integration of people with impairments in regular society. This is because changing views based on individual ideas and assumptions is more challenging. Ignorance, fear, or misconceptions are the most common causes of attitudinal obstacles. As a result, people with disabilities' strengths are often overlooked in favor of their limitation. According to Blackburn (2002), communities lack sufficient understanding and information on disability issues. The barriers to SRH services that WwDs experience are diverse; they are influenced by economic, educational, cultural, and political issues. PWDs have suffered abuse of their sexual, and reproductive rights as a result of prejudice, stereotyping, and discrimination.

Coerced sterilization and the compulsory administration of lifetime contraception are still carried out without the permission of WwDs. Women with mental illnesses are more likely to be subjected to forced abortions and sterilization (Mykitiuk & Chadha 2011). In the majority of reported cases, family made decisions on behalf of disabled women without their agreement (Ouellette 2008). Women with impairments are still seen as non-sexual or incapable of engaging in sexual behaviors (Chikumbu 2014). Sexual acts are not expected of them (Chikumbu 2014). Rugoho and Maphosa (2015) discovered that persons with impairments are perceived as hypersexual in African societies. Because they are seen as broken items, their misery has remained on the fringe of policymakers' attention (Choruma 2007). According to the World Health Organization, the primary challenge is the community's negative attitudes toward people with disabilities, which have become institutionalized and have caused untold pain to women with disabilities, particularly social labeling from society.

### Communication Barriers

These include the failure to provide sign language interpretation for persons with hearing impairment, inaccessible technology such as television without captioning, or websites that are inaccessible to screen readers used by persons with visual impairment. In regards to access to SRHR information women with disabilities have challenges in communicating their concerns to health professionals who do not understand sign language; hence, this becomes a barrier. Women with hearing loss encounter several problems (WHO, 2009). Literature development in Braille and other media is a difficulty in poor nations. According to Roberts (2006), deaf women are frequently misinformed due to difficulties communicating in sign language. Wilson & Monaghan (2006), and Groce et al, (2007), all note that there is insufficient literature for women with hearing impairment on SRH. Medical personnel in impoverished nations are typically untrained in sign language, making it difficult to converse with deaf women who attend health centers (Margellos-Anast, Estarziau & Kaufman 2006).

### Institutional Barriers

Institutional barriers faced by persons with disabilities in accessing services include organizational legislation, rules and regulations, practices, or processes that actively exclude or fail to facilitate access for PwDs. They are difficult to identify and are often linked with cultural norms. Human resources in the area of Recruitment and termination is discriminatory towards persons with disabilities. Women with disabilities continue to face institutionalized discrimination, isolation, and stereotyping (Rugoho & Siziba 2014). In both industrialized and developing countries, violations of women's sexual and reproductive rights have been tolerated. Governments and development partners have failed to provide inexpensive and accessible sexual and reproductive health services, particularly in developing nations (Groce et al. 2009; Swartz et al. 2009). According to Swartz et al. (2009) and Groce et al. (2010), women with impairments are still perceived as being unable to engage in sexual and reproductive behaviors.

### Cultural Barriers

Cultural Barriers may include myths and stereotypes about disability that are rooted in traditional and religious beliefs, as well as superstitions which often manifest in fear and misunderstanding about disability. Such barriers are closely linked with the traditional model of disability. People with disabilities are still considered as second-class citizens in the majority of African countries (Rugoho & Siziba 2014). Discussing sexual and reproductive problems with them would arouse their sexual impulses, and they would be unable to control their sexual wants. According to Hunt and De Mesquit (2006), European societies feel sorrow and sympathy for persons with impairments and frequently think that their physical appearance would preclude them from engaging in sexual intercourse. They are seen as ill persons who must first heal before engaging in sexual activity. Sexual practices would hurt them and make them much more disabled. According to Mgwili and Watermeyer (2006), South African societies believe that persons with disabilities lack the mental capacity to initiate or participate in meaningful sexual relationships. As Hunt and De Mesquite, (2006), discovered that women with impairments are frequently assumed to be incapable of carrying pregnancies.

### Information Barriers

These are barriers which prevent access for persons with disabilities to both the form and content of information that may be provided on websites, brochures, books, television etc. Persons with visual or intellectual impairments are particularly impacted by information barriers. Failure to provide information in straightforward, easy-to-understand language with graphics can be a barrier for people with intellectual disabilities, whereas tiny text or using a difficult-to-read typeface can be a barrier for those with visual impairments. According to Job and Prilleltensky (2004), adolescents who have any form of disability are denied the chance to learn about SRH when compared to their peers because of the fear of teachers, parents, and counsellors to discuss SRH with them pointing to the idea that they are non-sexual.

### Financial Barriers

Persons with disabilities experience financial difficulties as a result of limited work prospects, according to Dambi et al (2015) and Singongo et al (2015). Financial difficulties experienced by people with disabilities influence their carers as well, in that caregivers of children with disabilities forsake some potentially income-generating activities in order to provide care for their children who require regular attention. With such a time-consuming duty, it is difficult for them to find meaningful employment, resulting in financial difficulties in a financially demanding existence with no source of income. Aside from time restrictions, some businesses are just unwilling to hire someone with a handicap or parents of disabled children because they believe it would damage the quality of work produced. According to Patel, Baier, Baranov, Khurana, Gambrah Sampaney, Johnson, Monokwane, and Bearden (2017), moms of autistic children encounter financial issues in meeting specific educational needs, assistive equipment, and treatment fees. Zimbabwe has a high incidence of unemployment, which has impacted people with disabilities, notably women with impairments and some parents of disabled children, who are obliged to find alternative ways of income.

### Bronfenbenner’s Ecological Theory

The ecological model was used as the theoretical foundation for this study, which focuses on individuals, and their social interactions with their surroundings. According to the Broffenbrenners’ ecological model, an individual's direct surroundings impact the result of their life either in a good or bad manner. People live within complex systems that encompass their immediate surroundings, social connectedness, and groups that are embedded in a larger social framework (Bronfenbrenner, 1992,1995). It facilitates in the organizing of knowledge about people and their environment so that their interconnectedness may be understood. Individuals go through a number of life stages that all require environmental assistance and coping abilities. Health care, family relationships, insufficient income, mental health difficulties, conflicts with law enforcement agencies, unemployment, educational difficulties, and other social issues can all be subsumed under the ecological model, allowing practitioners to assess factors relevant to such problems (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010, p. 16). As a result, investigating the ecological circumstances of access to sexual and reproductive health for young women with impairments is crucial.

This study investigates psychological experiences of young women who have disabilities in receiving SRHR services using Bronfenbrenner's (1977, 1979) ecological paradigm. Factors at the micro- (e.g., parental knowledge of SRHR, caregiver-PWDs relationships), meso- (e.g., young women with disabilities' marital relationships, religios support system), and. macro-system levels of practice (e.g., cultural, racial and ethnic didifferences, and health provision). There are several risk variables in each field of the system, which may be divided into individual systematic level, micro systematic level, mesosystemic level, exosystemic level, macrosystemic level, and chronosystemic level (Clevelandetal.,2008). The individual system consists of the young WwDs' own personality traits and biological dispositions, whereas the micro, meso, exo, and macrosystems are nested within the young WwDs' settings and associations, and the chronosystem refers to the impact of disasters on access to sexual reproductive health services.

### Individual System Level

Individual structures and functions influence development, namely the individual's biology, psychology, and behavior (Wachs,2010). There are three categories of personality traits that have the greatest effect on the direction and strength of the proximal processes. Temperament, self-efficacy, tenacity, and other qualities are examples of forces that can initiate and maintain proximal processes. Mental and emotional resources such as experience, knowledge, ability, and skill for successful regulation of proximal processes, as well as social and material resources are examples of bio-ecological resources. They either aid or inhibit proximal process functioning. The individual differentiation of these three types of features leads in their grouping in person structure outlines, rendering individuals subject to psychological barriers to SRHR services and information.

### Micro-System

The micro-system, according to Bronfenbrenner (1977), is a pattern of activities, social roles, and interpersonal contacts experienced by an individual or a group of persons in a direct environment. Factors at the micro-system level, such as parenting techniques and parent-child relationships, can have a direct impact on young women with disabilities who are cared for by caregivers. The individual's most local surroundings is represented by the microsystem level. The environment comprises of people who have spent a significant amount of time in close proximity to the individual, such as relatives, peers, and neighbors (Hawkinsetal., 1986). It constitutes the individual's first and most personal learning context, which thereafter serves as their reference point., (Santrock,2012). Psychosocial challenges in accessing Sexual and reproductive health rights information and services can be enhanced at this stage. Family perceptions, beliefs and traditions towards access to SRHR information and services have either a positive or negative impact on an individual’s ability to access SRH services and information.

### Meso System

It relates to the relationships between the micro-systems in which the individual participates throughout a certain developmental era, for example work facilities, classmates, and the neighborhood (Berger,2003). Interactions between micro-systems pervade every aspect of an individual's life and promote his or her growth (Becvar&Becvar,2012). In this theory, the interplay of microsystems within this systems level is critical. This level has various different forms of interactions. The most fundamental type of interaction occurs when an individual enters a new setting, such as beginning university studies, moving to a new neighborhood, or church or graduating. These transitions separately have developmental consequences, (Championetal.,1995), that may influence one's perception of SRHR services and information.

### Exo System

The individual is not present at the exo-system level, yet events that occur here have an impact on the situations that include the individual. It relates to places like the caregivers' place of work (Bronfenbrenner,1992). It is thought to be a continuation of the meso-systems level. These levels might be official or informal, include or exclude important people, and often include any organization that makes choices affecting family, the repercussions that can be extensive and frequently inadvertent (Webster-Stratton, Reid, and Hammond, 2004). For instance, how the caregivers' work schedules impact their availability to care for SRHR services for their impaired children, or how the parents' wage schedule affects their capacity to meet their financial commitments. These effects might be demeaning to young women who are being cared for by caregivers or parents and thereby lose out on SRHR programs. When young women with impairments marry men who work, if they do not work themselves, they develop a sense of overdependence on the spouse. This fosters marital rape and SGBV situations in which young women with disabilities are unable to disclose abuse to authorities due to their reliance on the spouse.

### Macrosystem

The macro-system is the superordinate system that comprises cultural or sub-cultural patterns of stability, such as beliefs, conventions, norms, political tendencies, and communal behaviors (Bronfenbrenner, 1995). The principles specified by the components of this system's level impact all other ecological levels. This system has an impact on the way people conduct interactions. Individuals' experiences in the same situation will thus be somewhat comparable. Mgwili and Watermeyer (2006), for example, observed that South African societies see persons with disabilities as lacking the mental stamina to initiate or participate in meaningful sexual relationships. As Hunt and De Mesquite discovered, women with impairments are frequently assumed to be incapable of carrying pregnancies (2006). This has a psychological impact on young women who have disabilities.

### Chronosystem

Chronosystems includes the component of time by referring to what is going on around individuals and how the system levels are influenced by the past climate in the person's surroundings. The chronosystems level refers to the historical background as it happens at various system levels, as well as changes that occur in the individual's development context (Rateleetal.,2004). These changes might be internal (the individual's natural development in growth) or external, such as the family biography changing aspects that explains a caregiver-client connection, transgenerational and social disturbance (Prilleltensky,2003). It encompasses the historical variables at the macro-systems level that influence how families respond to pressures. The chrono-systems level comprises several temporal dimensions, including micro, meso/family, and macro time (Darling,2007). These aspects mitigate change across a person's lifetime. Events at the chronosystem level, such as catastrophes, will now have an influence on individuals' psychological well-being when accessing SRHR information and services..

Young women with disabilities are susceptible to psychosocial challenges in accessing SRHR services due to their vulnerability at all systems levels. Individual, environmental, and demographic variables all have an impact on vulnerability (Gritzetal., 2003; Hutcheon & Lashewicz, 2014). According to Sutherland and Shepherd, (2001), risk variables cannot be evaluated in separation and require a bio-psycho-social framework to make meaning of them. They highlighted that there may be individual and contextual disparities amongst young women with impairments who may and cannot access SRHR services and information. This highlights the importance of investigating the delinquent abuse of drugs within the setting of the ecological theoretic framework, as there may be factors at various system levels that influence the psychosocial problems faced by women who have disabilities in accessing SRHR information and services.

### Knowledge Gap

The previous studies that have been reviewed yield useful information, but however differ significantly in context with the situation of the young women with disabilities in the current study. Not much literature is available on the psychosocial experiences of young women with disabilities in accessing SRHR services and information hence this need to be addressed. While other research do address the factors in the environment that hinder access to SRHR services for women with disabilities. The I psychological aspect has not been incorporated into the studies. The gap in the knowledge is still wide, for the psychological challenges being experienced by young women with disabilities in accessing SRHR information and services. The current study seeks to inform interventions but not only targeting areas of service delivery but taking an ecological perspective at addressing issues at individual systematic level (individual perceptions), the society as a whole and in the event of natural disasters.

## RESEARCH METHODOLOGY

### Introduction

The preceding chapter focused heavily on the idea under study's literature research, taking notice of other scholars' perspectives on the problems experienced by young women with disabilities in obtaining SRHR services and information. The researcher's major focus in this chapter was expounding on the study methods. It covers the research strategy, research design, research tools, target population, sampling and sample size, data analysis and presentation, and ethical issues in the study. Because the study was more exploratory in character, the researcher used a qualitative research strategy for this particular study.

### Research Approach

This research was conducted using the qualitative research method that is exploratory in character. It examines the topic in a more subjective light, yielding more detailed data. It is a collection of interconnected views about the community that serve as a logical and theoretical foundation for the systematic investigation of that reality (Fieldstead, 1978). According to Bander, (2014), defines quantitative research as a scientific model that results in noticeable and quantifiable information on the region being examined. Qualitative research is defined as a interpretative paradigm that reflects a world in which objectivity is socially created and constantly shifting.

The researcher chose the interpretative paradigm primarily because it allowed him to grasp specific elements of the study from more of an individual’s standpoint. This is primarily due to the researcher's interpretation of data based on his own understanding. The interpretative research model holds that our understanding of reality is the outcome of social creation by human agents. (1979, Barrell and Morgan). As a result, it enables the researcher to obtain a better grasp of the environment around him. According to Firestone, (1998), "when a theory is based in evidence, it provides the researcher with the ability to comprehend as well as construct an explanation for the given phenomenon that is compatible with its occurrence in the social world." For numerous reasons, it was critical for the researcher to apply this paradigm in this study relevant to psychological concerns of young women with disabilities in accessing SRHR services and information. The first was that the study was more exploratory in character, relying significantly on data to provide appropriate analysis. It required information on the experiences of young WwDs in order to analyze their emotional expression and nonverbal cues beyond the words they stated. Therefore, this research relied on researcher's analysis on the findings.

"Qualitative research method is of tremendous importance for studying areas of sensitivity and emotional intensity," writes Padget (2008). As a result, the interpretative research paradigm provides more believable study results, particularly in sensitive domains. This simply indicates that the interpretation made by the researcher, or depiction of the participants fits the participant's viewpoint to a larger extent. This is related to the researcher's ability to accurately evaluate data. This was one of the primary reasons why the researcher chose the interpretative research methodology.  A lot of emotions were expected by the researcher to be involved since it is a very sensitive problem for young women with disabilities. As a consequence, the researcher predicted diverse feelings and reactions, and therefore the application of the interpretative paradigm would generate more trustworthy results. As a result, the research would be considered valid if the sentiments and emotions were correctly interpreted.

Furthermore, an interpretative model was applied to provide the researcher with a thorough understanding of the issue. To be able to analyze data, one must first have a thorough understanding of the subject. As a result, the researcher preferred it because of its subjectivity, as it brought numerous factors to the table relevant to young women with disabilities and the psychological issues they face. As a result, its subjectivity was required because it provided comprehensive experiences relevant to young women with impairments.

Data gathering is one of the most important aspects of qualitative research. Some researchers believe that the interpretative research paradigm is primarily concerned with data acquisition. It is multimodal, with the researcher expressing his or her own point of view. As a result, this was crucial for the researcher since it allowed him to examine some of the issues confronting young WwDs from a personal standpoint. As a result, the research's validity was purely relied on the scholar's lucidity of judgment based on the information that was obtained. It gave a great platform for the researcher to analyse the issue of psychosocial challenges faced by young women with disabilities basing on the ampleness and rationality of the account.

Another distinguishing feature of this paradigm is that it is realistic in nature. Social phenomena cannot be separated from their natural background, explanations must be established in a sociohistoric framework, (Carr 1994). Carr (1994), further states that this research paradigm is the interaction between the researcher and the participant and he believes that "one of the advantages of having an interactive interaction is that the researcher acquires first-hand knowledge that provides useful relevant data. This was more convenient to the researcher because of the nature of the subject of the research.

## Research Design

In order to collect data for this study, the interpretative phenomenological analysis (IPA) approach was used. Edmund Husserl established the phenomenological study design as an eidetic approach, and he was interested with how things look to individuals in their experiences. Husserl's pupil, Martin Heidegger (1962), eventually refined this approach into experiential philosophy and hermeneutics. Freeman (2008), felt that the interpretive phenomenological approach intends to grasp what it is like to be in someone's shoes, and that this is accomplished by interpretive action that makes meaning intelligible by translating it. Smith and Osborn, (2008), define the interpretive phenomenological analytical process as participants first make sense of their world and experiences, and then the researcher decodes the meaning to make sense of the participants' accounts. The phenomenological research design examines human experiences through the descriptions supplied by the persons involved, in this case the experiences of young women who have disabilities and access to SRHR services and information.

## Sample And Sampling Technique

Convenience sampling was implied in selecting participants. According to Salkind (2013) convenience sampling (sometimes called accidental sampling) is the selection of a sample of participants from a population based on how convenient and readily available that group of participants is. It is a type of non-probability sampling that focuses on a sample that is easy to access and readily available. The researcher identified NCDPZ as one of the largest organizations of people with disabilities in Zimbabwe with the largest members in both rural and urban areas across the 10 provinces of Zimbabwe. A sample size of 52 participants particularly those from Gweru whom the researcher could meet physically, included 52 young women with disabilities including those with physical, hearing, intellectual and visual impairment. This was done to assist the researcher in gathering thorough information on the experiences of young women with various impairments and their difficulties in accessing SRHR information and services, given that disability is not a homogeneous group.

## Research Instruments

There was use of semi-structured interviews. According to Paul et al. (2013), one of the most common approaches, particularly in psychological research, is to conduct interviews.

## Interviews

It is the process of asking questions to the interviewee directly (either virtually or face to face) in order to obtain a direct response. There are used to obtain information by asking a set of questions (Abawi 2013). Researchers use them when they feel the need to communicate directly with their subject, and verbal questions are presented to generate an oral response. For this study, the researcher chose semi structured interviews. Use of interviews were also suitable for the research because they allowed participants to express themselves verbally and nonverbally, which suited the exploratory nature of the research. Abawi (2013) stated that, "Semi structured interviews feature a number of scheduled questions, but the interviewer is allowed to change the phrasing and sequence of the questions in the interview."

Semi-structured interviews are in-depth interviews in which the respondent must answer pre-determined open-ended questions. The researcher with this type of interview asserts some level of authority by deciding which topics should be discussed. Semi-structured interviews allows the researcher to change the language in order to be on the same level of understanding with the respondent. For example, the researcher can replace the identical word that will be used on the pre-set question with a simpler one that provides for more clarity. Semi-structured interview also allow for the researcher to review and probe questions. According to A while and Barriball (1994), "probing may be a useful method for gauging dependability since it provides for explanation of key points expressed by the responder." As a result, the researcher can explore questions around the subject at hand. This has enabled researchers to obtain adequate credible information.

During the procedure, the researcher used an interview guide with pre-set questions for the participants to respond. Semi-structured interviews allowed the researcher to probe the individuals with questions. Probing inquiries are essential for determining dependability and gaining a fuller picture of what participants are experiencing. Interviews were quite handy since the researcher probed inquiries every now and then, giving him a clear knowledge of their accounts. In some cases, the researcher would probe questions and use words other than those in the interview guide to help the participant understand the question.

Reflecting on the same subject, semi-structured interviews assisted the researcher in gaining a deeper knowledge of the sensitive concerns. Some researchers believe that semi-structured interviews are best suited to investigate sensitive problems. Even though the questions were preset, they were left open-ended to allow the participants to express themselves fully. As a result, it was simple to obtain trustworthy data from the respondents. Because this design lets the participant to employ both verbal and nonverbal clues, probing participant to express themselves vocally or nonverbally enabled the researcher to collect extensive data..

### Data Collection Procedure

The researcher was guided by the need to satisfy the demands of the validity and reliability of the data collected when collecting data so she followed a few steps in ensuring so.

1) Ethical approval was granted by the Midlands State University department of Psychology to conduct the research (Appendix B). The letter served to inform NCDPZ organisation and participants which the researcher consulted that he was a student at Midlands State University who is working on this research.

2) Identifying the young women with disabilities with the age range of the research from the National Council of Disabled Persons of Zimbabwe.

3) Getting informed consent with the participants. After approaching the sampled 52 young women with disabilities who participated voluntarily, the researcher introduced the topic of the research to the women and shared the objectives for the research. Ethical considerations such as privacy and confidentiality of information were told and the women were eager enough to participate. had time to introduce herself to the participants.

4) The researcher conducted additional in depth interviews with 2 caregivers and 2 officers from NCDPZ. The researcher took notes during the interview session also he made use of current technology where he tape recorded the interview for use in his data presentation and for further evaluation after the interview.

### Data Analysis And Presentation

Data analysis will be done in an interpretive phenomenological manner, which means that a detailed reading of the data will be performed in order to obtain a holistic perspective so that future interpretations remain grounded within the participant's account, initial themes will be identified and organized into clusters and checked against the data, themes will then be refined and condensed and examined for connections between them, and finally a narrative account of the data will be produced (2006). After each interview, the researcher will produce an interview summary to convey the findings. The interview summary will include the location of the interview, the time and duration of each interview, and the outcomes of each interview. The researcher will utilize graphs to evaluate, interpret, and arrange it, as well as make comparisons with literature..

### Ethical Issues The Study Was Guided By The Following Ethical Principles:

**INFORMED CONSENT** - Permission was sought and granted from the National Council of Disabled Persons of Zimbabwe, (NCDPZ) to conduct the research. Participants and key informants provided verbal and written informed permission after ensuring the privacy and confidentiality of interview information and participant identification. Participants' thoughts and recommendations were also respected. The participants are informed of the research objectives and given permission to participate. The interviews were conducted in private, in an open and conducive setting. Data was saved on the researcher's laptop, which has a password and is not accessible to unauthorized individuals.

Consent ensures that subjects are freely engaging in the study and are fully aware of the risks and rewards. A pivotal position in which the individual must know all of the facts that might logically impact their willingness to participate in a way that they can comprehend (Brent et al, 1988). The research should inform participants about the following: the purpose of the study, the expected period and processes, the participants' rights to decline participation and withdraw from the research once it has begun, and factors that may influence their enthusiasm to participate, such as potential risks, discomfort, or hostile effects.

**CONFIDENTIALITY**- Because there were delicate topics, the researcher ensured the secrecy of all material acquired. It is an explicit or implicit guarantee given by a researcher to a study participant that any information submitted to the researcher will not be disclosed to the public. As a result, the findings of this investigation were kept private. To conceal the respondents' identity, pseudo names were utilized.

**ANONYMITY** - of the responders was carefully followed. When the subject's identity cannot be connected to personal replies, anonymity is safeguarded. Marianna (2011). (2011). The researcher noted the idea of privacy, which was keeping a degree of confidentiality of the participants' credentials unidentified. This was done to safeguard and ensure participants that they would not be harmed because no one could truly tell who participated or not.

**HONESTY-** In all technical communications, the researcher will strive for honesty, reporting data, results, methods and procedures, and publication status. Data fabrication, falsification, or misrepresentation are all prohibited. It is also not acceptable to deceive colleagues or the general public. As a result, the researcher will make the results available to the group while respecting individuals' privacy.

### Characteristics Of Participants

The participants in this study were 52 people (52 young women with disabilities). The 52 young women with disabilities had an age range of between 18-35 (26 single ladies and 15 married and 11 separated from their spouses). 14 had various forms of physical impairments, 14 with hearing and speech impairment, 10 had an Intellectual Impairment and 14 with visual impairment. Among them included 7 of the disability advocates from the organization who are also young women with disabilities.

Some of the participants where mindful of confidentiality and privacy whilst some were willingly participating without the need for confidentiality. While the study engaged a larger group of young women with disabilities (52), it was not feasible to include all individual experiences in the final analysis. Therefore, a representative sample of ten participants was selected for in-depth presentation. For confidentiality and ethical considerations, pseudonyms were assigned to each of these participants. The participants data and information is presented in table form (below) and each participant is identified with a pseudo name for the sake of their confidentiality.

Tables 1

| Pseudo name | Age | Gender | Type of impairment. | Marital Status | Highest Level of education. |
|---|---|---|---|---|---|
| Chipo | 19 | F | Physically Impaired | Single | Secondary |
| Jenny | 21 | F | Visually Impaired | Single | Primary |
| Sally | 22 | F | Visually Impaired | Married | Secondary |
| Linda | 22 | F | Physically Impaired | Single | Tertiary |
| Sarah | 26 | F | Physically Impaired | Separated | Secondary |
| Eliza | 28 | F | Hearing impaired | Single | Primary |
| Hope | 30 | F | Hearing impaired | married | Secondary |
| Mary | 32 | F | Visually Impaired | Separated | Secondary |
| Nyasha | 19 | F | Intellectually Impaired | Single | Tertiary |
| Betty | 35 | F | Physically Impaired | Separated | No education |

Relating to the research, respondents who had vast experiences were chosen basing on their different types of impairments in accessing SRHR services and information. The researcher included the following age, gender, type of disability/impairment, and highest level of education.

### Gender

The researcher wanted to get real life experiences of young women with disabilities in accessing SRHR information and services. Henceforth the researcher focused on females, young women with disabilities to be particular.

### Age

The researcher's age range was 18-35, which encompassed women with impairments in their adolescence. Aside from being young ladies with impairments, this provided some commonality in their experiences to the age range. According to Gross (2010), "in Erickson's psychosocial phases of development, a healthy individual must enable adaptive conduct to overcome maladaptive behavior." In this regard, most young women with disabilities at this age and stage in life were attempting to access SRHR information and services on the same basis as others, but they faced unique challenges.

### Type Of Impairment

The researcher incorporated women with various types of disabilities in order to get the full picture of their experiences in accessing SRHR information and services. This is because disability is not a homogeneous group but rather a heterogenous group. There are various types of disabilities and among the participants were those with physical impairments such as amputees, those with muscular dystrophy and those with cerebral palsy, hearing impaired and those with visual impairment. Their experiences were totally different hence the need to capture in all experiences in their diversity.

### Highest Level Of Education

The researcher included the aspect of level of education to the categorisation matrix. This is because one's level of education would correlate to individual experiences to accessing SRHR information and services. The researcher assumed that the more educated one was the more likely-hood that they would prioritise SRHR information and services. This also correlates to the social status, cultural beliefs and economic stability of the family to which one belongs.

### Marital Status

Another key aspect to put into consideration is the marital status of the target participants. From the ages 18-35, there is a greater chance that most women get into intimate relationships, some get married, and others in the same period get to divorce and/or separate with their husbands. For this study the selection was random including all women with various marital backgrounds to participate and share their experiences.

There were themes that arose during data collecting that were going to be employed for research analysis. It should be emphasized that they evolved from the study topics, and that sub-themes emerged from those themes. The themes and subthemes that were used for data analysis are shown in the table below.

Table 2

| THEME | SUBTHEME |
|---|---|
| Understanding the concept of SRHR. | Knowledge on SRHR.<br>Experience in accessing SRHR services. |
| Psychological challenges | Fear of stigma and discrimination<br>Low self-esteem<br>Perceptions on SRHR |
| Sociological challenges | Social disengagements<br>Family Support Systems<br>Cultural beliefs |

| | | |
|---|---|---|
| Interventions | Intervention from the organization.<br>Intervention from the community. | |

**Theme 1: Understanding The Concept Of Srhr.**

In this part of the research, the researcher was concerned with getting an in-depth detail about experiences of young WwDs in accessing SRHR information and services. However to begin with, the researcher had to assess respondents knowledge on the concept of SRHR so as to e on the same page with them for validity and reliability of the research. Respondents outlined their experiences and how they are managing.

**Subtheme 1: Knowledge of Sexual and reproductive health and rights.**

One third of the respondents demonstrated adequate knowledge on what SRHR is and also attributed the knowledge to education they got. Education from school on Sexual and reproductive health facilitated that the young WwDs knew much on SRHR. However, two thirds of the respondents did not have a clear understanding of what SRHR is. The respondents who lacked know how on SRHR narrated their lack of knowledge sigthing the following

*"I grew up in a family were information on SRHR was and is considered a very sacred thing in my family. My parents never taught me on this subject hence am not informed in that subject till this age. Unfortunately, unlike my fellow peers who managed to go and learn more on SRHR at school, I didn't get the opportunity because many schools could not enroll me because of my condition. Special schools are expensive and my parents could not afford to take me there"*, Betty narrates.

Eliza stated the following, *"Sexual and Reproductive Health and rights is a new term for me. In school we were taught on the different genitals between women and men and defining them. We were never taught of any rights associated to that. Maybe it was our curriculum that did not incorporate that aspect on sexual rights at our deaf school"*. The researcher then asked if any information was taught at family level, she responded, *"I grew up in a family of 6, my siblings are not hearing impaired as I am, so most probably if they discussed that information it missed me."*

In trying to explain the sexual and reproductive health rights subject most of them thought its basically not being in a position where you can be sexually abused. The researcher had to briefly tell them that Sexual and reproductive health rights goes beyond that. Most of them especially those who reached tertiary level were informed on the subject but still had some knowledge gaps.

**Subtheme 2: Experiences in accessing SRHR information and services.**

The young women with disabilities shared their diverse experiences in accessing SRHR information and services probably due to their different types of impairment. The experiences differed from physical barriers they faced, communication barriers, attitudinal barriers, institutional barriers and information barriers that they encountered.

Chipo narrates, "*When I go to health facilities to access contraceptives, I am faced with infrastructural accessibility challenges. Most of the clinics I visit are still lacking on ramp development to accommodate me and my wheelchair. So, nurses would have to carry me from one entrance to another, which is quite burdensome on them and also not right with me. I want to enjoy independence."*

Hope stated, "*The Lack of Sign language interpreters at health facilities remain an issue of concern. I am an adult woman now with 2 children but when I go to clinics to receive SRH services, I have to go with my Sister so that she can assist in interpreting what I need to the health personnel. At some point I was wrongfully prescribed"*

Sally also states, "*As a woman with visual impairment, it is a known fact that going to the hospital seeking for SRHR services is like going there to entertain the nurses. They would gather themselves around you asking you* *silly questions, such as if I ever enjoy having intercourse not knowing the person I am having intercourse with. Its a very sad experience working with nurses with such bad attitudes."*

*"They would feel pity on me when I was pregnant , blaming my husband for having me pregnant when I have this condition, viewing me as asexual."*, Nyasha says.

### Theme 2. Psychological Challenges

The participants of this study research had psychological challenges that they encountered in regards to accessing SRHR services and information. These were fuel by individual and societal beliefs.

#### Subtheme 1: Fear of Stigma and Discrimination.

Stigma and Discrimination are common attributes when it comes to persons with disabilities in accessing services. However, the fear of being stigmatised and discriminated calls for concern. The respondents highlighted this through their different stories.

"*The health facilities are not safe zones for us persons with disabilities. As for me, I am never going to visit clinics around here because of how I am treated. The health personnel before saying anything, just their look at you as you advance towards them is scary for me, it speaks disgust."*, Sally says.

*"I do not feel safe speaking with my workmates on issues pertaining to my relationship and sexuality because I do not want to end up inviting negative comments against myself.*", Linda says.

"*I once attended a wedding and the Pastor there was teaching the new couple saying they should not be promiscuous in marriage for the Lord will punish them with a disabled child. Ever since then going to public events has been quite a scare for me." ,* Nyasha speaks.

#### Subtheme 2: Low Self-esteem

The respondents sighted that they have self-esteem challenges and stress from interactions around SRHR due to the toll it has on their social lives.

"*Being a woman with a disability is difficult, knowing that chances of getting marriage are very slim compared to our counter parts without disabilities. Whenever matters of relationships are spoken I tend to isolate myself or shy away from the conversations because I know I am human too and I need to be loved and to love someone, but the mere thoughts that I might not get married and have my own children because of my condition eats me deep.*" Chipo said.

"*For me, whenever discussions on hereditary disease comes in I develop a fear of passing the same condition to my child , hence interaction on SRH frightens me".* Jenny said.

#### Subtheme 3: Perceptions on SRHR

Perceptions are considered as the conscious understanding of something. Most respondents did not really know the term SRHR but were somehow knowledgeable on the need to avert from unsafe sexual practices, with an HIV scare mindset. However, their perception on attaining SRHR services and information were distorted due to a number of reasons.

*"SRHR is not important as long as someone abstains from sexual activities. STIs and HIV are acquired through unsafe sexual intercourse with affected partners.", Betty said.*

*"Sexual rights are for man, women we are just subject to men's decisions, there is no way I am going to detect the number of children I want to have yet my husband is there.", Sally said.*

*"……I was physically, emotionally and sexually abused by my then husband, but kept quite fearing what the community would say. However, I couldn't take it anymore and made the best decision of my life leaving that man. Although at first I wasn't aware it was my right to say no to some behaviours of my then husband". Sarah narrated.*

**Theme: Social Challenges In Accessing Srhr Srvices**

Young women with disabilities are faced with a myriad of social challenges that emanates from micro level to the influences at chrono level. Attitudes of the society towards access for young WwDs to SRHR services and information, the discrimination associated to it is one of the major challenges faced by the young women in accessing SRHR services and information.

**Subtheme: Social exclusion in SRHR Programs**

The participants reported to have disengaged themselves in community programs on SRHR. Other participants willingly excluded themselves while others were excluded by the society itself. Some participants noted that they were not privy on the importance of accessing SRHR information whereas some reported that it was uneasy to be at a gathering with other people when you are thinking about the way they would be viewing you.

"I do not see the value of wasting my time going to SRHR programs because most of the programs do not carter for me as a person with hearing impairment. Lack of Sign language interpreters is a clear sign that I am not part of the program." Eliza said.

"The SRHR programs are conducted at venues where I as a person who uses wheelchair find it difficult to access, the environment is my barrier". Sarah said.

"I would rather continue with my business than go and attend a SRHR program, I do not see how it impacts my life , judging from my condition", said Chipo.

The participants pointed out that the SRHR programs are subtly excluding them in programming as they fail to carter for them and considering their needs.

**Subtheme: Family support systems.**

Family is a very important institution for all of the participants. The correlation between a supportive family and access to SRHR is positive. In the same vein 4 of the respondents noted that they received support from some of their family and friends in regards to accessing SRHR information. Most of the respondents however noted it differently pointing out that their families lacked urgency in issues to do the SRHR. They attributed it to lack of awareness on this subject among their caregivers and their families. Some respondents also noted that other people other than family for example the church, neighbours and school offered them support, through provision of SRHR information. With the church putting much of the contribution through youth trainings. This is what they had to say.

*"I grew up in a very religious home, my family has always been supportive and loving. However, the topic on SRHR has not always been popular amongst us. Hence the only time we could learn on sexuality and relationships was at the church through youth trainings.", s*ays Nyasha.

*"Its never easy to communicate issues of SRHR at home, I would tend to talk with my peers. Family is however supportive when I need assistance going to the health facilities, but having them know what I am going there for becomes an issue", Sarah.*

It is evident that among young women with disabilities family is very supportive as well as peers and the church. However the idea of one going to collect contraceptives with the knowledge of the family sends forth a different message.

**Subtheme 3: Cultural beliefs**

Cultural Barriers may include myths and stereotypes about disability that are rooted in traditional and religious beliefs, as well as superstitions which often manifest in fear and misunderstanding about disability.

"*When I visit some health facilities, they feel pity and sorry for me because of my disability and often conclude that my physical appearance would not allow me to have sexual intercourse. They view me as a sick person who need to heal first before I indulge in sexual activities." Sandra further states that, ".... they think sexual activities would harm me and further disable me".*

*"People perceive that I am a person who does not have enough mental strength to start or be involved in any meaningful sexual relationships. They think I am not strong enough to carry pregnancies as observed".*

*"My first boyfriend was so in love with me, but ever since he went with me to show me to his relatives, his affection changed. I am sure the family influenced him saying that I will bring disability curse to the family"* Mary said.

**Theme 4: Intervention Measures**

In this section main discussion is about the suggestions that were brought forward by the respondents on the ways that they could be assisted by the community or health facility. It was an approach of finding out how the community at large can help and embrace young women with disabilities.

**Subtheme 1: intervention from the health facility**

In this section the researcher aimed at attaining strategies in which can be used to assist young women with disabilities access SRHR services. The respondents pointed to one major key factor that needed to be addressed, which is the attitudes of nurses and other health personnel. The participants noted that more sensitization is needed towards the attitude of nurses when addressing young women with disabilities in accessing their SRHR services.

*"I think if the nurses would be sensitized more on handling persons with disabilities without showing stigmatization, the health facilities would be our safe haven for SRHR services and information. This attitude they display push us to seek for services elsewhere since the clinic will not be accessible and welcoming to us"* Linda says.

*"Health facilities should ensure that they have prowess in sign language so that communication is made easier for us women with hearing impairment. But most importantly nurses should be more welcoming than scary"* Eliza said.

**Subtheme 2: Intervention from the community**

The respondents were of the idea that communities and even institutional policies should ensure disability inclusion is prioritised. Psychosocial challenges they face base their foundation on these barriers they face.

*"What stresses me the most is not the fact that I might fail to access the health facilities , but the harsh treatment of the staff at the premises of health. Some deny us access hiding behind institutional regulations such as we are not allowed to accommodate people with your condition according to company policy. Hence we end up seeking alternative means to get ourselves the SRHR services we might be needing."* Linda said.

## DISCUSSION OF FINDINGS

This study explored the psycho-social barriers young women with disabilities (YWWDs) face in accessing sexual and reproductive health and rights (SRHR) services and information. Drawing from semi-structured interviews with 52 participants, the findings reveal interlocking barriers situated at multiple socio-ecological levels, ranging from the individual (microsystem) to institutional (exosystem) and cultural/policy spheres (macrosystem). This section discusses how these findings support or diverge from existing literature and offers insight into how disability, gender, and SRHR intersect within Zimbabwe's socio-cultural context.

### 1. Psychological Barriers (Microsystem)

Participants consistently reported psychological challenges such as fear, anxiety, and low self-esteem, largely rooted in internalized stigma and past negative experiences with SRHR services. These psychological effects were driven by societal beliefs that positioned women with disabilities as asexual or incapable of parenthood (Chikumbu, 2014; Hunt & De Mesquit, 2006).

These findings align with Rugoho and Siziba (2014), who found that women with disabilities in Zimbabwe often internalize societal rejection, leading to mental health struggles. The fear of being labeled, ridiculed, or denied services at health facilities discouraged many participants from seeking SRHR care. For example, one respondent explained how "the nurses looked at me with disgust and asked why someone like me would even need contraceptives."

Within Bronfenbrenner's framework, these challenges are rooted in the microsystem, particularly the individual's self-perception and their immediate interactions with family, caregivers, and service providers. The internalized stigma represents a psychological barrier formed by repeated negative reinforcement in one's immediate environment.

### 2. Social Barriers and Exclusion (Mesosystem)

The mesosystem, which involves the interplay between key environments such as family, peers, religious groups, and schools, was shown to have both enabling and disabling influences. Some respondents reported support from close relatives and church youth programs in accessing SRHR information. However, the majority experienced exclusion.

Family dynamics were often protective or dismissive. Caregivers tended to avoid discussing sexuality, driven by overprotection, ignorance, or shame. For instance, one participant noted: "My mother always said I didn't need to know such things, that no one would ever want me."

This confirms earlier work by Groce (2004), who emphasized that family attitudes are often a direct reflection of broader social stigma and contribute significantly to SRHR exclusion. The mesosystem challenge, therefore, lies in how intersecting influences from family, church, and school environments reinforce silence and inaccessibility around SRHR topics.

### 3. Structural and Communication Barriers (Exosystem)

At the exosystem level, institutional and community-based structures—including health centers, SRHR programming, and media—were not adequately inclusive. Participants reported inaccessible health facilities, lack of disability-friendly communication (e.g., no sign language or braille), and non-participation in local SRHR outreach.

Some SRHR programs were found to subtly exclude YWWDs by not tailoring materials or venues to be accessible. This supports the observations by Handicap International (2018), which highlighted that mainstream SRHR interventions in Southern Africa often overlook the needs of persons with disabilities.

The participants' exclusion from these spaces not only impeded access to information but also reinforced the idea that SRHR is not for them. These are clear failures in community-level and organizational design, rooted in ableism and ignorance—placing the responsibility squarely in the exosystem domain.

### 4. Cultural and Policy-Level Barriers (Macrosystem)

The macrosystem, comprising societal norms, religious beliefs, traditional practices, and national policy, was found to significantly shape access. Deep-seated cultural and religious beliefs often framed disability as a curse or punishment, creating an undercurrent of fear and misinformation that discouraged SRHR access.

Many participants reported being perceived as unworthy or inappropriate candidates for marriage or motherhood. These beliefs—echoed in studies by Rugoho and Siziba (2014) and Yeo & Moore (2003)—position disability as incompatible with sexuality, love, and reproductive agency.

Moreover, the lack of policy enforcement around inclusive SRHR services suggests a disconnect between Zimbabwe's ratification of international human rights frameworks for example the United Nations Convention on the Rights of Persons with Disabilities and local implementation of the National Disability Policy. This policy-practice gap exemplifies a macrosystem failure that entrenches exclusion and reinforces stigma at all levels.

### 5. Linkage Across Levels: A Multilayered Barrier System

The findings demonstrate that no single barrier exists in isolation. Rather, psychological, social, structural, and cultural challenges are interlinked across ecological levels. For example, a young woman may internalize stigma (microsystem) due to her family's silence on SRHR (mesosystem), which is exacerbated by exclusion from community programs (exosystem) and shaped by patriarchal norms (macrosystem).

This multilevel analysis reinforces Bronfenbrenner's proposition that human development—and by extension, access to health and rights—is the result of complex interactions across nested systems. Therefore, interventions must be comprehensive: targeting individual empowerment, family and peer education, institutional reform, and national policy transformation.

In sum, this study confirms that young women with disabilities experience multi-layered psycho-social challenges in accessing SRHR information and services. These challenges align with existing literature and are distributed across Bronfenbrenner's socio-ecological model. Moving forward, effective interventions must engage all levels—individual, community, institutional, and policy—to ensure equitable and inclusive SRHR access, in alignment with the principles of the UNCRPD and Zimbabwe's National Development Strategy 1.

Here is a professionally rephrased version of your Intervention Measures section, clearly integrating the socio-ecological approach (Bronfenbrenner's model) to structure the recommendations from the respondents:

### Intervention Measures: A Socio-Ecological Approach

This section presents intervention strategies suggested by the respondents to improve access to SRHR services and information for young women with disabilities. These proposals emphasize the need for multi-level engagement—from health institutions to families and broader community systems—reflecting the interdependent layers of the socio-ecological model.

### 1. Community and Family Engagement (Mesosystem & Microsystem)

At the mesosystem level, respondents emphasized the importance of community-based interventions that involve families, local leaders, religious groups, and peer networks. Awareness campaigns and inclusive community dialogues were recommended as tools to challenge stigma and cultural misconceptions surrounding disability and sexuality.

Within the microsystem, respondents stressed the role of family and close social networks in either supporting or hindering access to SRHR. Many participants reported that overprotective or uninformed caregivers, and issue of negative masculinity due to strong patriarchal backgrounds limited their autonomy. Therefore, targeted education for families is necessary to shift harmful attitudes and empower young women to make informed decisions about their reproductive health.

### 2. Health Facility-Level Interventions (Exosystem)

Respondents highlighted the critical role of health institutions in facilitating access to SRHR services and information. However, negative attitudes and discriminatory behavior by healthcare providers, particularly nurses, were identified as significant barriers. This points to the need for continuous disability inclusion training and sensitization of healthcare personnel. Strengthening institutional practices and accountability within the exosystem can help foster a more respectful and inclusive environment for young women with disabilities.More so, there is need to ensure that the SRHR information is distributed in accessible formats.

### 3. Policy and Social Norm Change (Macrosystem)

Participants also called for policy-level change to reinforce inclusive service delivery and address the systemic roots of exclusion. This includes advocating for stronger enforcement of national disability and SRHR policies, and ensuring these frameworks are translated into practice at local levels. Furthermore, shifting deeply ingrained societal norms and prejudices—rooted in traditional and religious beliefs—requires ongoing social mobilization and collaboration with cultural gatekeepers. These strategies align with interventions at the macrosystem level of the socio-ecological framework.

In conclusion, the recommendations provided by respondents underscore the need for integrated, multi-level interventions that address both the immediate and structural barriers to SRHR access for young women with disabilities. A socio-ecological approach offers a comprehensive roadmap for designing inclusive, responsive, and sustainable programming.

## CONCLUSION

Young women with disabilities face multiple barriers when attempting to access health care and sexual and reproductive health (SRH) services. They are often excluded and marginalized due to a range of interlinked factors, including negative attitudes from service providers who stereotype or label them unfairly, lack of information in accessible formats, non-inclusive institutional policies, and inaccessible health facilities. Additionally, deeply rooted societal beliefs—such as the misconception that women with disabilities are asexual, unattractive, or inferior—further hinder their access to essential services (Groce et al., 2013).

These barriers contribute significantly to the psycho-social challenges experienced by young women with disabilities, including low self-esteem, internalized stigma, and fear of seeking care. While the World Health Organization affirms that persons with disabilities are just as sexually active as those without disabilities, their sexual and reproductive rights are frequently overlooked and denied. These challenges are embedded across all levels of the socio-ecological model, highlighting how individual, interpersonal, institutional, and societal factors intersect to exacerbate the psycho-social burden for young women with disabilities seeking SRHR information and services.

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