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"They Do Not Perceive Us as People": Women with Disabilities' Access to Key Social Services During the COVID-19 Pandemic: A Zimbabwean Case Study

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Abstract
This study sought to discover how women with disabilities (WWDs) fared at the height of the COVID-19 pandemic with regard to access to key social services. Fieldwork was conducted in April 2022 among 104 women in three low-income areas of Caledonia, Epworth, and Hatcliffe within Harare Metropolitan Province. The key social services studied are information, water, health, education, and protection from gender-based violence (GBV). The study utilises the structural violence and social suffering theoretical lenses to analyse the institutionalised marginalisation of women with disabilities in relation to access to basic social services during the COVID-19 era. Findings reveal that the pandemic amplified the marginalisation, inequities, exclusion, and challenges confronted by persons with disabilities (PWDs) in general and, specifically, gender and social class inequalities faced by poor women in the Zimbabwean society. The intersection of vulnerabilities arising from gender, social class, disabilities, and the pandemic itself created insurmountable challenges for WWDs. Resolving these challenges is important to creating an inclusive environment for WWDs to thrive. The government, local authorities, and NGOs need to mainstream disability issues in service provision regardless of whether or not there is a pandemic.

Keywords COVID-19 · Inequalities · Women with disabilities · Exclusion · Social services

Introduction and Background

The unprecedented COVID-19 pandemic resulted in the general disruption of everyday life for ordinary people across the globe. Coping mechanisms were not evenly shared among different populations situated in different localities, particularly those who barely afford to provide for themselves, even under 'normal' circumstances. Those who were already on the fringes of society had their challenges amplified by the pandemic, despite intervention measures put in place at different levels of governance to combat the pandemic and its effects. In light of this, we focus on how the pandemic affected the lives of WWDs living in three low-income areas of Harare Metropolitan Province. We observe how the intersections of class, gender, disability, and level of education among others, complicated the life chances of women with disabilities in relation to access to health, information, education, protection from gender-based violence, and water in the low-income areas of Epworth, Caledonia, and Hatcliffe.

We use the structural violence theory to unravel how social structures, if not managed with the subaltern populations in mind, can violate the life chances of people located

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at the margins of social, political, economic, and cultural milieu. Less educated women with disabilities from low-income areas represent one such population whose life has been constrained by the social structures within which individuals exist. We focus on how government imposed lockdowns, movement restrictions among other COVID-19 induced measures, and compounded the challenges WWDs faced in accessing service delivery systems. This qualitative research is based on structured interviews and focus group discussions with 104 women in Epworth, Caledonia, and Hatcliffe. Seven key informant interviews were conducted with representatives of organisations working with women with disabilities in Harare.

The Situation Before the COVID-19 Pandemic

The World Disability Report of 2011 estimates that about 15% of the world population lives with disability (WHO, 2011). In 2017, the national disability prevalence rate was stated as 9% with a higher number of females than males (Zimbabwe National Statistics Agency (ZIMSTAT) and United Nations Population Fund (UNFP), 2017). Researchers lament the paucity of research on disability issues in developing countries (Winzer & Mazurek, 2015).

Using the International Classification of Functioning, Disability and Health (known more commonly as ICF) officially endorsed in 2001, disability is perceived from both the medical and social models (Eide & Ingstad, 2011). While the biomedical approach focuses on individual diagnosis and treatment, the social model focuses on the context of disability (Agmon et al., 2016). From a social perspective, there is a vicious cycle of poverty and disability. While disability may lead to or further increase poverty, poverty may delay health-seeking behaviour and expose people to unhygienic environments and health risks, thus leading to disability. Generally, in sub-Saharan Africa, there is an overrepresentation of persons with disabilities (PWDs) among the poor (Eide & Ingstad, 2011).

Zimbabwe's economic woes have reversed the gains that had been made in the 1970s and 1980s regarding rehabilitation and social services offered to PWDs (Banks et al., 2017). The adoption of neoliberal ideals has resulted in unimaginable poverty and crisis through privatisation of social services and disinvestment of the state in public spending (Cahill, 2011; Mate, 2018; Sachikonye, 1995; Whitehead & Crawshaw, 2012). Notable within the reduction of public spending is a reduction of state funding on education, housing, health, and social protection among other critical areas. The 1990s Structural Adjustment Programmes resulted in the withdrawal of the state from the provision of social welfare including disability funding, leaving non-governmental organisations and the donor community as the primary welfare providers.

The 2000s Fast Track Land Reform Programme ostensibly meant to redistribute land to thousands of blacks from minority white farmers, attracted economic and political sanctions from Western powers, and further derailed the country's fragile economy resulting in unprecedented inflation and general economic, political, and social meltdown. Though the country temporarily improved during the government of National Unity between the ruling ZANU PF and the opposition MDC (2009–2013), the 'second republic' led by Emmerson Mnangagwa since 2017 has registered yet another phase of a hyperinflationary environment and general economic meltdown. The repressive state apparatus has resulted in censorship and general loss of freedom and infringement of human rights including during the COVID-19–induced lockdowns (Chiweshe & Hove, 2023).

While certain social services are defined as rights such that their provision is not a privilege, their presence is not guaranteed for individuals to enjoy their full rights. Such social services include information, education, water and sanitation, health, gender-based violence (GBV) services, and transportation. Resource constraints and the general marginalisation and invisibility often limit PWDs' access to such social services. For example, in terms of provision of health, anti-retroviral therapy (ART) and HIV/AIDS-related services, the limited resources and the overburdened nature of health workers make it challenging to handle issues of disability together with HIV/AIDS (Banks et al., 2017; Rugoho & Maphosa, 2017). Other barriers such as centralisation of services and mobility challenges related to the geographical distances involved in accessing services compound an already bad situation. While it is true that once diagnosed with either HIV or a disability, an individual is entitled to free basic rehabilitation/HIV services and certain drugs (including ART) through the public health institutions, there are still certain incidentals and out of pocket expenses that one must meet. Access to services may also be limited by people's beliefs and myths about the causes of disability and other social conditions. For example, disability is often believed to be caused by witchcraft and so is HIV (Banks et al., 2017; Muderedzi & Ingstad, 2011). Generally, the participation of WWDs in the public sphere and access to services such as transport tends to be limited because of lack of assistive technology (Lewis, 2004).

The COVID-19 Pandemic and Social Services in Zimbabwe

Major crises and disasters require quick government action and generally expose the poor and disabled to greater risks than other social classes by widening the already existing gaps and fissures in society (Eide & Ingstad, 2011; Pincock et al., 2022). In terms of health, COVID-19 compromised and disrupted sexual and reproductive health (SRH) across multiple dimensions: individual-level access, health

systems functioning, and policy and governance (Nandagiri et al., 2020, p. 83). Mhiripiri and Midzi (2021) explain how crises may close access to information for PWDs; consequently they studied some of the complaints and lawsuits made by people with disabilities regarding lack of access to information. Chiweshe and Hove (2023) explored how women human rights defenders had no room for manoeuvre during the pandemic. Social exclusion of PWDs characterised much of the COVID-19 vaccination programming in Zimbabwe (Muridzo et al., 2023).

Conceptualising Access to Services by Women with Disabilities in Zimbabwe

Very little might be in the control of WWDs, in terms of access to service provision; the major economic, social, and political contexts generally determine the poor people's access to opportunities to affect one's circumstances. The situation of WWDs may thus be viewed as one where people experience social suffering and structural violence (Kleinman et al., 1997; Farmer, 1999, 2004; Rylko-Bauer & Farmer, 2016). Borrowing from Eide and Ingstad (2011) people experiencing social suffering face conditions that are beyond their control and "structural violence is the violence of everyday life that causes social suffering, as well as the extraordinary violence of war and other disasters that are beyond the control of the individual person with a disability and his/her family" (Eide & Ingstad 2011, p. 10). This violence is woven into the societal structures, histories, ideologies, and institutions (Pincock et al., 2022, p. 872). Therefore, instead of blaming women with disabilities for their situation, it is necessary to understand how their contexts create social suffering and expose them to structural violence. In this article, we therefore pay attention to institutionalised forms of marginalisation that limited WWDs' access to basic services within the COVID-19 context, and how those very institutions contributed to the women's social suffering. Pincock et al., (2022, p. 871) used similar lenses to study how COVID-19 exposed the state's inability to "commit, coordinate and cooperate" to deliver equitable and inclusive policies to the citizenry.

Methods and Setting

Design, Setting, and Sample Characteristics

This paper is based on a dataset collected in a study conducted in April 2022 utilising a qualitative research design. Data were collected simultaneously using structured interviews, focus group discussions (FGDs), and key informant interviews. In total, there were 42 structured interviews, five FGDs with 62 women with disabilities, and seven key informant interviews with service providers and professionals working with women with disabilities. Qualitative data allowed us to capture the experiences of disability, its intersection with gender, and the ways in which women's marginalisation was institutionalised during the COVID-19 pandemic. Following the Miles and Huberman (1994) framework for data analysis, researchers engaged in three iterative steps of data reduction, data display, and conclusion drawing and verification. Data displays were done using tables, charts, and graphs drawn from frequencies, cross-tabulations, and percentages. The Statistical Package for Social Sciences (SPSS) version 20 was utilised for this purpose. While the broad study explored the lived experiences of women with disabilities at the height of COVID-19, the current paper presents findings on women with disabilities' access to key social services during the COVID-19 pandemic.

Besides the NGO records and statistics of people with disabilities, at the time of study there were no state records of official numbers for disabled population residing in the three study locations. The lack of data compounds the invisibility and marginality of people living with disabilities. This further magnifies the paucity of knowledge on the risk rate of women with disabilities in Zimbabwe including during COVID-19, and its impact on their lives. A two-phased approach was adopted in order to arrive at a less arbitrarily determined sample of research participants. Firstly, it involved extrapolating population estimates from the registers of the Jairos Jiri Association (JJA), an organisation that works with people with disabilities in Zimbabwe. The registers' statistics totalled 416, 227, and 748 for Epworth, Hatcliffe, and Caledonia respectively, giving an estimated total of 1391 people living with disabilities in all the research sites. We then applied the UN 2019 female to male individuals with disabilities global ratio of 19.2:12 to arrive at the approximate number of women living with disabilities of 852 in the study area.

Purposive sampling was used to select 104 women with disabilities from the population using registers from JJA. JJA used the following disability criteria (visual, hearing, speech/communication, physical, cerebral palsy, epilepsy, intellectual/learning, psychosocial, multiple disabilities, and albinism) to ensure a fair representation of each category of disability. Participants with physical disabilities constituted the majority (48%), followed by those with hearing impairments (14%), the visually impaired constituted 12%, intellectual/learning 5%, cerebral palsy 4%, those with albinism 3%, speech/communication 2%, and epilepsy and psychosocial disability 1% each while the remaining 10% had multiple disabilities. This sample represents about 12% of the total population of women with disabilities in the three study areas. However, the sample did not statistically represent the proportions of the women with disabilities in the three study sites, due to logistical issues and also because the exact numbers of the people with disabilities

Table 1 Age profiles of research participants

Age of participants	Number of participants	Percentage
18–19	8	7.7
20–29	10	9.6
30–39	22	21.1
40–49	38	36.5
50–59	13	12.5
60–69	10	9.6
70–79	1	1
80 +	2	2
Total	**104**	

were not known (especially for Caledonia where JJA had no programmes running). Memon et al. (2020) acknowledge the various factors affecting the determination of the sample size, including practical considerations. This sample was considered adequate, in line with recommendations by Memon et al. (2020), that for behavioural sciences, a sample between 30 and 500 is adequate. Table 1 below shows the age profiles of research participants.

Table 1 reveals that the majority of the sample participants (67.2%) fall within the reproductive age group of 20–49. For such individuals, it is key to provide access to birth control/reproductive services, safe sex, educational services (for children), employment, information, water, sanitation, and hygiene services.

The three sampled geographical areas are former commercial farms generally characterised as poor, informal settlements and to some extent 'chaotic and disorganised', lacking basic services and amenities such as roads, water, and electricity (Chari, 2021). Epworth is a satellite town located within Harare Metropolitan province about 15 km from Harare city centre. Hatcliffe is within Harare city about 21 km away from the Central Business District (CBD) while Caledonia is also within the city of Harare but located 22 km from the city centre. A common characteristic of these three areas is that they are connected in one way or the other with Harare CBD where most populations eke out a living. The ability to access the Harare CBD is key in getting essential services and employment. Therefore, COVID-19 containment measures such as lockdowns adversely affected people from the study sites particularly PWDs who could not easily adapt their CBD-based livelihood strategies to other geographical spaces.

Research Ethics

The researchers took several measures to ensure adherence to ethical principles of confidentiality, informed consent, voluntary participation, avoidance of harm, and giving feedback to participants after the study was concluded. Informed consent was sought from all participants who gave consent for audio and video recording. In data processing, analysis, and publication, the identity of the participants is protected through the use of pseudonyms for both the quantitative and qualitative components of the study. In addition, ethical clearance was obtained from the Midlands State University. A validation meeting was held in Caledonia with some of the research participants (about half of the sample). Researchers provided transportation to and from the venue.

Trustworthiness and Validity of Findings

Stahl and King (2020) emphasize the importance of ensuring that findings approximate reality. Table 2 below summarizes the steps employed by researchers to ensure trustworthiness of findings.

Presentation of Findings

The key services are information, education, health, water and sanitation, GBV, and transportation services.

Information on COVID-19

Most participants (excluding the hearing impaired) revealed that they accessed COVID-19 information through the radio in addition to getting the information via word of mouth from neighbours, family members, and acquaintances. A few, particularly those without visual impairment, highlighted that they accessed the information through social media and television. The radio was also popular with the physically and visually impaired. Most residents in Epworth

Table 2 Steps taken to ensure trustworthiness

Step	Process
Transferability	Provision of a thick description of context and justification of methodological choices
Confirmability	Provision of verbatim extracts from participants and key informants
Dependability	A detailed description of the methodology
Credibility	Triangulation of multiple data collection methods and data sources Validation of findings meeting with participants

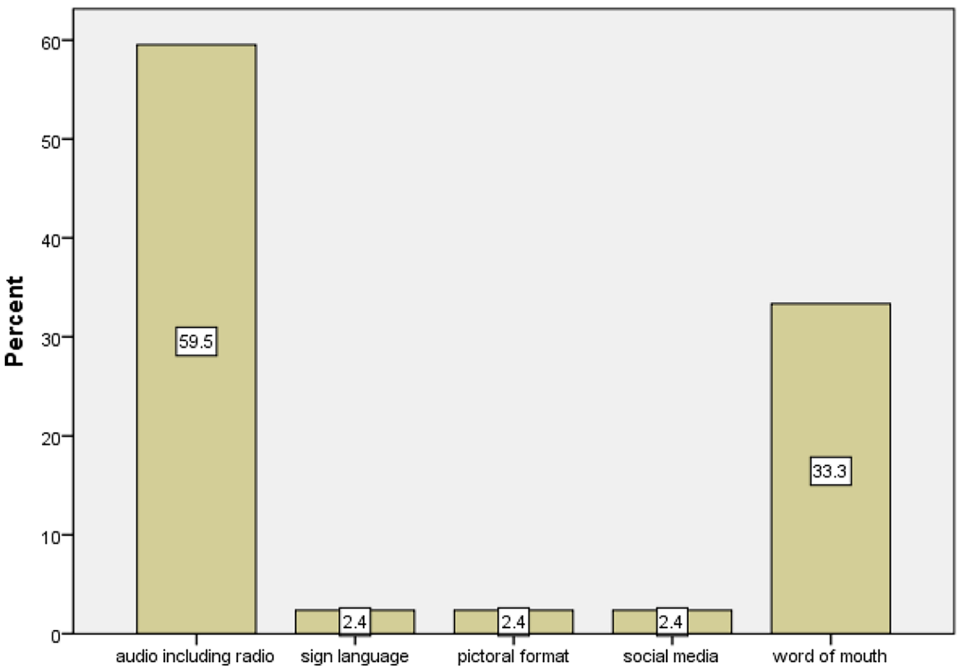


Fig. 1 Method of transmission of COVID-19 information to participants

and Caledonia possessed radio sets, while a few could watch solar-powered television sets. The absence of electricity connection in Caledonia, Epworth, and parts of Hatcliffe also implied that a few households had access to television since solar equipment required to generate sufficient power for television was beyond the reach of most households. However, those in some parts of Hatcliffe where there is electricity connection also had access to television including satellite television. Figure 1 below indicates these realities.

Accessing information for the hearing-impaired participants was difficult. They relied on communication from friends and family members who can communicate using sign language and visual sources such as pamphlets and posters. It was more difficult for the illiterate and hearing impaired as they were unable to read and interpret the visual sources. Likewise, those with visual impairments highlighted that little COVID-19 information was made available on braille. A key informant (KIN4) strengthened this argument stating that due to the restrictions on movement and also the fear of contracting COVID-19 the communication with persons with disabilities was affected. They argued:

> We could not effectively use phones…some do not have phones or data or both…they do not have TVs… sometimes sign language interpreters are not on TV…

Participants also said they learnt about the pandemic through awareness campaigns and road shows that were conducted in Hatcliffe and Caledonia by the Ministry of Health and Child Care and NGOs. Amplifiers allowed residents to listen to, and get information from, the roadshows from their homes. Three key informants stated that their organisations also engaged the national broadcaster (Zimbabwe Broadcasting Corporation) for jingles and informative advertisements on COVID-19 through radio and television. One key informant (KIN7) indicated that their organisation posted information on their social media pages including Facebook and WhatsApp, but some key informants however maintained that their information was rather generic and not particularly tailor-made to suit specific groups of people or women with disabilities. Another key informant (KIN4) stated that their organisation also used the print media, such as the daily newspaper, the *Herald* and the weekly *Sunday Mail*. The organisation would publish a weekly column covering issues of COVID-19, including its impact on persons with disabilities in the *Sunday Mail*. The effectiveness of such strategies, particularly the print media, might however be limited given the resource constraints, especially in accessing the online version of the newspaper.

Though they confessed ignorance to the causes of the pandemic, generally, participants knew about the signs and symptoms of COVID-19 and preventive measures. However, there appeared to be variations in terms of preventive measures adopted by the different groups of women with disabilities. During fieldwork, it was observed that all participants, except the visually impaired, wore face masks. This variation could have been because much of the communication and demonstrations about the wearing of masks may have been presented pictorially and thus benefitting those that can see. It must be noted though that the wearing of masks negatively affected those that use sign language as they rely on lip reading to communicate (Kubenz & Kiwan, 2021). Most participants reported that they used herbs including ginger, mint, the indigenous *Zumbani* (Lippia

Javanica), honey, garlic, and lemons to do steaming to boost their immunity against COVID-19. Information about these home remedies was shared through trusted social networks.

Women with Disabilities and Participation in COVID-19 Programming

Most participants noted that the government had not consulted them, and thus, they were unable to participate in COVID-19 programming. They blamed the government for not considering the needs of women with disabilities in the process. Participants also confessed their ignorance of COVID-19 response programmes. They noted that our research was the first to engage women with disabilities specifically to discuss COVID-19 issues. They complained that the government does not consult or engage them in developing valuable programmes including COVID-19 programming. As one participant noted:

> They [the government] do not care what we think. They do not perceive us as people. (FGD-Caledonia).

Key informants, except those in government departments, also stated that they did not participate in COVD-19 programming and the government did not consult them, particularly during the first phases. They are still lobbying for the government to recognise the place of people and women with disabilities in COVID-19 response and programming. As one key informant noted:

> There was little consultation even at national level... we were not involved…we had to muscle our way in... there was nothing, zero…no opportunity to contribute.

However, a key informant from a government ministry stated that their department participated in the COVID-19 response initiatives at national and provincial levels. Their department, for instance, was invited to National Response Team meetings and they also ensured that quarantine centres observed reasonable accommodation for people with disabilities. The inclusion of the needs of PWDs became key. The key informant stated that 'our song was inclusion', although they maintained that the actual participation and inclusion of PWDs in general and WWDs in particular, still needs to improve:

> The challenge is the attitude. We have an attitudinal barrier. Women with disabilities you know were perceived/seen as children and minors but it is a double discrimination for women with disabilities…the problem is the barrier. If we remove the barrier…women with disabilities will participate… You cannot plan for persons with disabilities. You plan with them.

Lack of participation and information resulted in the arrests of some participants. For instance, those with hearing impairments were often arrested during the first lockdown, as they were ignorant of the lockdown measures. They highlighted that quite often, the government needs to avail interpreters. Thus, sources of information are limited especially for women with hearing impairments. Others pointed out that they were aware of ongoing programmes such as vaccinations (24%) and awareness campaigns (12%) programmes as indicated in Fig. 2.

Among the interviewees, 48% got the vaccination shot once, twice, and even thrice. However, the remaining 52% were skeptical of the vaccines. They chose not to get vaccinated due to various reasons including fear of the unknown, misinformation on the effects of vaccines (some thought they

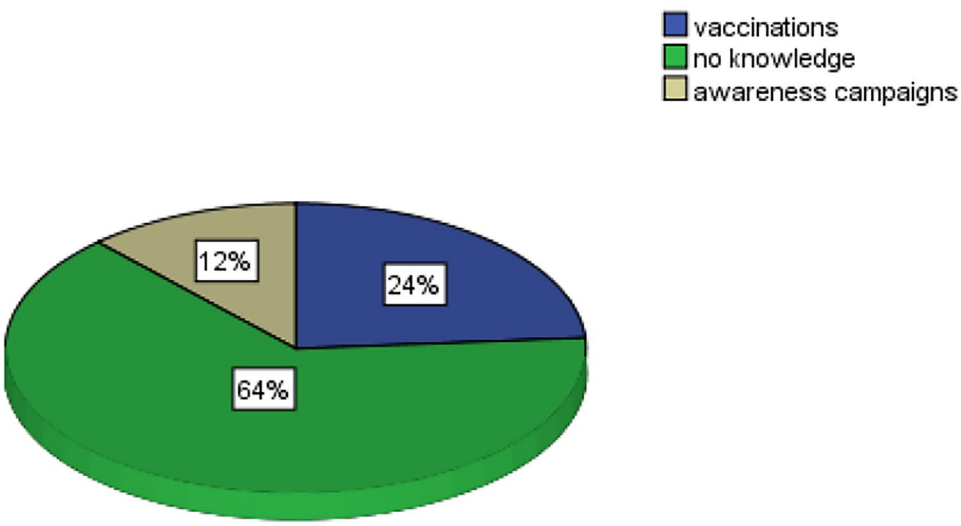


Fig. 2 Participants' knowledge of national COVID-19 programmes

could worsen their disabilities or even kill them), and lack of identity documents (even though these are not requirements) among others. To buttress the above point, one key informant (KIN3) had this to say:

> When the vaccine came people didn't even know what kind of vaccine they were being given, what is the effect of that vaccine, or what is the efficacy. You know, these were details that only people who are well educated, who are well versed in everything will tell you. The women with disabilities that we engaged with didn't know what kind of vaccine they had. Some didn't even know that the vaccination programme had started even in the rural areas. So, we find that the information is available to people who are outgoing, and who have got the resources, especially during COVID-19.

Access to Health Services by Women with Disabilities During COVID-19

General Medical Services

The pandemic in general and the lockdown in particular resulted in challenging implications on health services delivery for women with disabilities particularly concerning access, care, and treatment. However, despite the challenges, some services remained accessible throughout. Participants in Epworth reported that the local clinic remained open and the nurses and doctors were available. Mobile clinics were also available in all the sites under study. It is important to note that 95% of the participants did not have access to medical insurance and they thus found it difficult to get medical services. The lack of medical insurance is not surprising in a population that mainly relies on informal sector earnings. These earnings tend to be too low and irregular to cater for the payment of monthly medical insurance premiums. Figure 3 shows the desperate situation of these women.

Because of a lack of medical insurance, participants had to dig into their meagre resources to pay for medical requirements. The majority of those interviewed (71%) stated that they paid in cash for all their medical requirements which were mostly at the local clinics, 17% relied on donors and the government, and 12% stated that they used home remedies and did not seek Western medicine. The requirement to pay user fees limited the extent to which participants visited healthcare facilities. The majority decided to simply stay at home because the facilities were financially out of reach. Beyond the stated financial constraints, women also reported other barriers to access to health services. These included the long distances involved, long queues, perceived negative attitudes of health personnel, and unavailability of the requisite medicines.

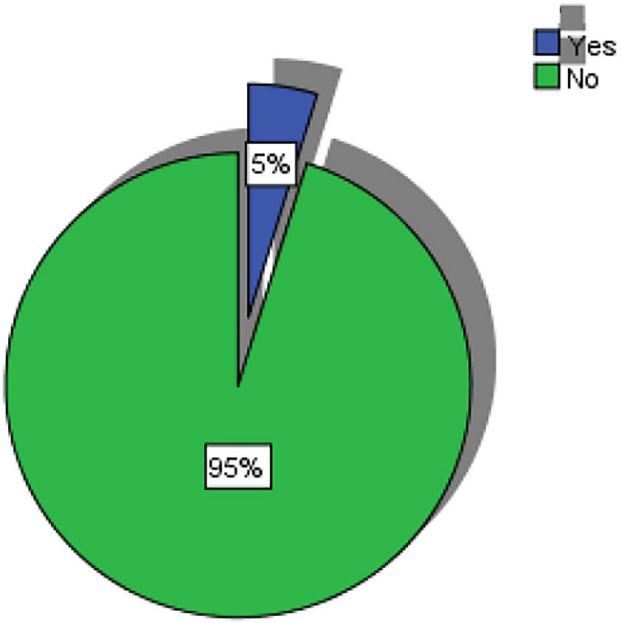


Fig. 3 Participants' access to medical insurance

HIV/AIDS Management

Those on HIV treatment reported that they could access ART treatment from their usual collection centres. Other participants had reservations about visiting health institutions for fear of contracting COVID-19, after hearing that people were dying in numbers in the hospitals because of COVID-19. They thus chose to stay at home. Participants also noted that disability made it difficult for them to access the services of mobile clinics. Sometimes mobile clinics would pass by without their knowledge, and in some cases they would miss the mobile clinics.

However, some participants with chronic illnesses other than HIV-related reported that accessing medication from pharmacies was difficult particularly during the lockdowns as most local pharmacies were either closed or open for a few hours. Some would open clandestinely and that often resulted in clashes with law enforcement agencies resulting in arrests for violating lockdown measures. Persons with disabilities found it difficult to manoeuvre such conditions as it was difficult for them to flee from the police and the army. In some cases, accessing medicines involved walking long distances since transport became a problem especially during the lockdown periods. It was particularly difficult for those with physical impairment to access medications. Resultantly, participants resorted to 'stocking' medicines, while in some cases they would involuntarily abscond from treatment after running out of medication.

The acute shortage in medication was also noted by the service providers. A key informant (KIN7) explained:

> ...it was damaging to an extent that 80-90% of our clients defaulted on medication…Most if not all council clinics and government hospitals did not have this drug. And accessibility in terms of reviews, there was nothing…some (patients) had relapses and others died.

Sexual and Reproductive Health

Some sexual and reproductive health (SRH) services and contraceptives also became difficult to access, particularly during the lockdown period. Participants noted that condoms and birth control pills were in short supply as local community health workers were afraid to distribute them for fear of contracting COVID-19. Participants also complained that prejudice against women with disabilities was apparent in the manner in which health workers distributed contraceptives. As one participant noted:

> They are rude. They will ask us, "what do you need them [contraceptives] for with your [disability] condition, especially in this COVID-19 [context]?" (FDG, Epworth)

A key informant also had this to say on GBV and sexual reproductive health:

> We also saw forced sterilisation among women with disabilities, *vamwe vonopihwa mapiritsi* (others are given birth control pills) and used as sex slaves and this is only protecting the perpetrators and doing nothing for that girl... I saw that for that girl, while we are saying ethically there is a thin line because some would say you will get many children, but to force sterilisation on them also I don't think it's a good thing because they have got the right to have children and so forth. So, I think that *ehmm* some of these cases *ehmm* because women are also dependents so they are shy to speak out because the moment they speak out the support will be withdrawn, they are not independent to live by themselves.

The quotation above indicates the dilemmas confronting both the women with disabilities and those that care for them when it came to reproductive rights and choices. While it is known that reproduction is a right, in reality, for WWDs, there are many barriers to exercising the right.

While the non-disabled could find ways of accessing condoms and other contraceptives, it was difficult for women with disabilities to do likewise. Some ended up with birth control methods that they were not used to. One participant reported that she decided to opt for an injection hoping that it would bring to an end her need for daily uptake of birth control pills. Like some women with disabilities, during that period, she fell pregnant. Generally, participants reported that unplanned pregnancies became prevalent among women with disabilities. Other participants noted that they were afraid of contracting the coronavirus from their partners; thus, they decided to become celibate when their partner exhibited COVID-19 symptoms. Consequently, in some cases, their partners would engage in extra-marital sex. Some said they would clean themselves including their private parts, with herbs, before and after sex as protection from the (corona) virus. Others would drink natural remedies before and after sex or kissing. Those who were vaccinated said they could have sex without fear of contracting COVID-19.

Access to Water by Women with Disabilities During COVID-19

There is no piped water connection in Epworth and Caledonia while poor service delivery has also halted the provision of piped water in Hatcliffe. Thus, in all the three study sites, residents depend on community boreholes and private wells for water for domestic use (including menstrual hygiene) and this poses a serious threat to the provision of clean and safe water. Some households managed to dig wells where they fetched water. It was observed that most WWDs did not have those wells at their homesteads. They, therefore, depended on neighbours who give them access to water at their whim. Some paid monthly subscriptions of at least $2 USD for the 'maintenance' of the well. Participants noted that such money was used to buy floor polish, tins, or ropes for use at the well.

While the water from wells and boreholes is generally available during the rainy season, it is erratic at best and unavailable at worst during the dry season (August to November). During that period, participants ended up buying water from private suppliers coming from other areas including nearby farms. Water could be sold for $0, 20 cents (USD), per 20-L bucket. Such amounts were too high for WWDs whose livelihoods were disrupted by the pandemic.

Access to water also becomes a challenge for WWDs, especially those with physical and visual impairments, as they have to depend on other people to carry water for them or at least, to assist them with fetching water. Those without children or other family members were mostly affected as they depended on well-wishers to carry or fetch water. In some cases, they paid the non-disabled to fetch water for them. Figure 4 indicates the nature of wells where some participants fetched water showing how these are difficult to manoeuvre for women with disabilities.

In most cases, access to water, particularly community boreholes, was embroiled in community politics which often worked to the disadvantage of women with disabilities. This usually happened in the dry season when private wells ran dry. Residents thus flocked to community boreholes (bush



Fig. 4 A dugout well. Source: Authors' fieldwork

pumps) which are sunk deeper making them a more reliable source. These require operation by hand and may be heavy to push up and down. Residents' pressure on the boreholes often forced those seeking water to spend an average of 6 h in the queue, waiting for their turn to fetch the precious liquid. A typical bush pump looks like Fig. 5.

As indicated in Fig. 5, manually operating the bush pump borehole which must be pushed up and down to draw water is a heavy task for PWDs who may require assistance using this technology. Such boreholes were often manned and managed by 'borehole security guards' (touts) who controlled queues. These men were often involved in corrupt dealings and they made residents pay in cash or kind, in exchange for jumping the queue. They called this practice '*kambijana*'—'just a little'. *Kambijana* could be money (between $1 and 2 USD), often depending on the amount of water sought. This amount was often beyond the reach of WWDs who constituted the poorest of the poor in these communities. They were not given priority at community boreholes, yet standing in long



Fig. 5 A typical borehole (bush pump) in Zimbabwe. Source: Authors' fieldwork

queues was difficult for PWDs, particularly those with albinism, who could hardly withstand the heat. They thus spent more time at the borehole for little or no water at all since they could not afford the required bribes. Moreover, WWDs could not withstand the pressure in cases of stampede and disorder at the borehole queues. In some cases, WWDs were discriminated against and physically or verbally abused at the borehole queues. As one participant described during in a FGD in Epworth:

> The boreholes are difficult for us. You hear some people shouting [saying] "all disabled people get far away from our buckets lest you will drool and contaminate our water. You will make us sick, it's not our fault you are disabled" (FGD, Epworth)

Out of desperation, some WWDs revealed that they paid '*kambijana*' through transactional sex with the borehole guards during the lockdown for them to beat the lockdown curfew. They would jump the queue in exchange for sex the following day. That further exposed them to unplanned pregnancies and sexually transmitted diseases (STIs) including HIV/AIDS. Participants revealed that the 'guards' did not expect them to use protection because as one participant noted:

> they think that they are doing us a favour [by having sex with us]. They think that since we are disabled, we are starved [for sex] and so they think we should never negotiate for safe sex.

Key informants also revealed that there is a general belief that PWDs are asexual. The politics of access to clean running water for women with disabilities ran counter to the whole discourse of constantly washing one's hands under clean running water as an antidote against contracting or spreading the coronavirus.

GBV Services

Lockdowns and homestays exposed women with disabilities to GBV, including rape. However, participants noted that reporting GBV cases is usually difficult and this was aggravated by the lockdowns where police officers expected people to stay at home. Participants reported that the police were not approachable and at times were dismissive of complaints and (attempted) reports by WWDs. As one participant noted:

> If we report to the police, we are always asked to bring the perpetrator. At times they [the police] ask for sex. It's like they work for the same company as the perpetrators (FGD, Epworth)

Talking to or reporting through mentors for PWDs (community-based health promoters) also proved difficult for participants. They stated that the mentors were often bribed by the perpetrators. Further, mentors were also accused of disclosing

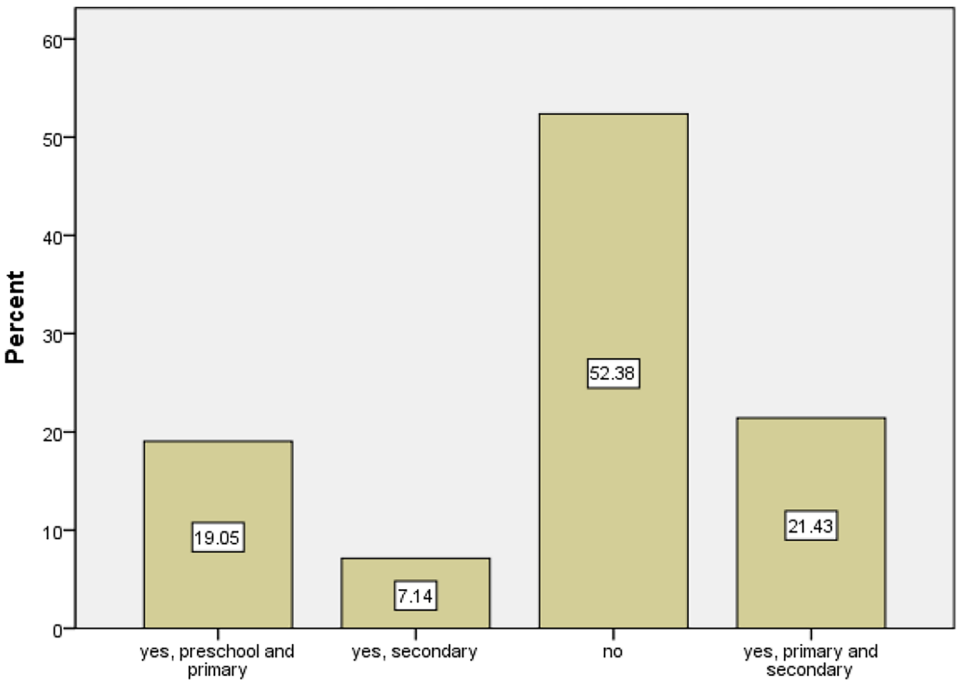


Fig. 6 Participants' responses on whether they have school-going dependents

participants' secrets. Those who sought the services of mentors also said that the pandemic and lockdowns sometimes made it difficult to seek audience with their mentors.

Access to Educational Services During COVID-19

Participants were not enrolled on any educational programmes except for four young women. One was still in the primary school level while the others were at the secondary school level. These reported that it was difficult for them to access education facilities during lockdowns and after. One of the participants who was visually impaired learned at a school for PWDs, about 40 km from Harare. She indicated that the lockdown was a major setback for her as she could not access Braille facilities in Caledonia. There are no braillists in her neighbourhood; and thus, she had no access to teachers. The two young women who participated in the FGDs also noted that the WIFI data bundles required for online lessons were beyond their reach. Additionally, they blamed the government for not doing much to ensure reasonable accommodation for PWDs in lesson delivery during the lockdowns.

Similarly, WWDs reported that it was difficult for them to ensure adequate resources needed by their children for online learning during the lockdown. Gadgets such as smartphones, iPads, computers, and data bundles were not affordable to most women. Lack of access to reliable power sources also made it difficult for the few with smartphones to attend online lessons. Figure 6 shows that women who participated in individual interviews have a burden of looking after schoolchildren. While just above half of them (52%) indicated that they had no school-going dependents, almost half of the group (48%) had school-going dependents and these found it hard to carry out this role during the COVID-19 pandemic.

Most of the interviewed women considered the inability to raise school fees and buy uniforms and stationery as the most stressful issues during the COVID-19 pandemic. It is worth noting that the pandemic coincided with a general economic meltdown in the post-Mugabe era in Zimbabwe. This resulted in most government workers resorting to industrial action. Teachers went on strike citing an erosion of their salaries, resulting in children failing to attend lessons. To circumvent the negative effects of teachers' strike, some parents engaged teachers for private/extra lessons. Women with disabilities reported that such arrangements were difficult for them as they could not afford the private/extra lessons. Teachers would charge anything from $2 USD to $5 USD/week for private lessons. Thus, children of women with disabilities were excluded. Lack of money also meant discrimination from teachers and other pupils as the following excerpt shows:

> The [COVID-19] situation made it difficult for our children at school. They are always looked down upon by others at school. It hurts. (FDG, Hatcliffe)

Additionally, our research revealed that the government has built few schools and cannot adequately accommodate all children in our study sites. All four schools in Caledonia are privately owned, with government schools located in Tafara

and Mabvuku, 7 km away. There is also a proliferation of private schools in Epworth and Hatcliffe. While private schools in high-income areas generally provide better education, the opposite is true for private schools in low-income areas where this study was conducted. Such schools generally offer poor services but they are an option for the economically disadvantaged populations because of their flexibility in enrolling students without proper identity documentation (such as birth certificates) and academic records such as grade 7 results. This flexibility is not possible for government schools; thus, some women with disabilities who did not have proper documentation in their own right were subsequently unable to secure birth certificates for their children or those that had challenges raising the needed school fees ended up sending their children to such schools. As indicated in the figure above, raising school fees and buying uniforms and stationery were the biggest headaches for women with disabilities.

The low-income private schools in our study sites also became a better option for some participants as they allowed children to be enrolled without proper/adequate uniforms. Participants revealed that government schools in Epworth required pupils to have a complete set of school uniform comprising shirts, shorts, skirts, dresses, cardigan jerseys, tracksuits, a pair of socks, shoes, and sportswear before a child is enrolled. In most cases, schools include the cost of their fees for newcomers. The amount for all costs including first-term fees sometimes exceeded $250 USD/child. As such some participants revealed that they ended up opting for low-income private schools where $65 USD would be adequate for a child to start school. But during the lockdown period, those private schools also ended up demanding high fees for online lessons which most parents with disabilities could not afford, and this resulted in low performance for their children. Other women pointed out that economic hardships during COVID-19 made it difficult for them to secure examination fees for their children in public examination writing classes (grade 7, ordinary and advanced levels). Some eventually missed examinations.

Discussion

Disability tends to lead to stigmatisation which is usually accompanied by multiple socioeconomic deprivations and social exclusion (Agmon et al., 2016). Globally, research shows that even under 'normal' circumstances, WWDs in resource-constrained countries have limited access to services such as health and education and are at a higher risk of poverty and violence (Kubenz & Kiwan, 2021; Women Enabled International (WEI), 2020; WHO, 2022) The results demonstrate that during the COVID-19 period, women with disabilities faced multiple layers of exclusion, human rights violations, and the perpetuation of existing prejudices.

Like other nations, Zimbabwe has a well-developed legal and policy framework on disability issues that includes a progressive Constitution (Government of Zimbabwe, 2013), which guarantees the rights of PWDs, the 2021 National Disability Policy, the Disabled Persons Act (DPA) of 1992, and other auxiliary statutes. In addition, Zimbabwe is a signatory of the United Nations Convention on the rights of persons with disabilities. While on paper Zimbabwe has a comprehensive list of social protection schemes targeting vulnerable groups including WWDs, the reality is that these programmes are not operating efficiently (Mupedziswa, 2017).

From the above findings, it is clear that COVID-19 heightened and exposed existing fractures, fissures, and structural issues surrounding access to the said rights: social security, education, sexual and reproductive health, freedom from sexual violations, and other rights that women with disabilities must enjoy (Nandagiri et al., 2020). COVID-19 entrenched social exclusion, explained by Mtetwa and Nyikahadzoyi (2013) as a systematic blockage from accessing rights, opportunities, services, and resources that are normally available to other members of society. It emerged from the study that for women with disabilities' access to information, water, health, education, and gender-based violence (GBV) services was compromised during COVID-19. Other scholars (Muridzo et al., 2023; Goggin & Ellis, 2020; Smythe et al., 2022) argue that the rights of PWDs were already compromised pre-COVID-19 and that COVID-19 amplified the structural exclusion. A life of exclusion leads to poverty and social deprivation (Mtetwa & Nyikahadzoyi, 2013). Zimbabwe's poverty situation and failing infrastructure and service delivery were already dire before the advent of COVID-19. By 2020, it was estimated that half of the country's population was now living in extreme poverty (Goba et al., 2022). It is important for the government to demonstrate political will by enforcing and mainstreaming the well-meaning legal and policy framework that guarantees PWDs, and in particular WWDs, their rights to social services that include water, health, education, and GBV services.

The study elucidates that women with disabilities were excluded from COVID-19 programming and information. The exclusion was twofold: firstly, the non-availability of COVID-19 messaging for PWDs; secondly, inappropriate messages. Examples were the exclusion of sign and Braille messages where such 'disability COVID-19 messaging' was available. The exclusion exposed how COVID-19 programming lacked consultation and involvement of PWDs in the planning and implementation of COVID-19 interventions.

This exclusion affirms the argument that, too often, persons with disabilities are left behind in emergencies (Kuper et al., 2020), reinforcing the notion that PWDs face greater healthcare barriers than those without

disabilities (Okoro et al., 2018; Smythe et al., 2022; WHO, 2022). Faced with myriad barriers arising from COVID-19 presented above and the existing societal intersection of disadvantages and structural prejudices, WWDs were at a great risk of sexual exploitation (Rugoho et al., 2022; WEI, 2020).

Women with disabilities tend to face discriminatory and disrespectful behaviour from health professionals (Matin et al., 2021). When it comes to sexual reproductive health services, these professionals, together with the general public, also tend to assume that either women with disabilities are or ought to be asexual (Peta, 2015, 2017; United Nations Population Fund (UNFPA) & Women Enabled International (WEI), 2021) or that they are hypersexual with childlike characteristics (Agmon et al., 2016; Rugoho & Maphosa, 2017). In both cases, there is a perception that the sexuality of women with disabilities must be controlled. Where these women engage in sexual activities (especially with the non-disabled men), there is an assumption that they are being done a favour and should be grateful for the sexual service. The findings confirm these assumptions. Generally, women with disabilities are seen as vulnerable prey by sexual predators and thus exploitable targets (Rugoho & Maphosa, 2017).

On the marriage market, women with disabilities may be perceived as of 'low value' and 'burdensome' compared to their non-disabled sisters; thus, they are more likely to be abandoned by their spouses (Lewis, 2004). This leads to perceiving those with disabilities as not fully human (Agmon et al., 2016) and thus become victims of forced sterilisation which violates their rights to found families (van Trigt, 2020). Such thinking fuels ableism and goes against the African philosophy of *Ubuntu* which values personhood, self-respect, and respect for others.

While disability is not a choice and affects every sphere of human existence (Winzer & Mazurek, 2015), there are costs that come with the status and these can be managed and dealt with if the state mainstreams disability in the provision of social services. Such costs not only accrue to the disabled individual but the whole family too. There is need to analyse how disability affects the family and leads to a 'disabled family' because of the burden of care and support associated with such situations which takes away family members' valuable time and increases their workload (Muderedzi & Ingstad, 2011; Rugoho et al., 2022).

Limitations

The study used a qualitative approach using structured interviews, focus group discussions, and key informant interviews. While researchers were assisted by personnel from JJA in terms of communicating with those with who were deaf, more could have been achieved if the researchers had the skill to use sign language. Another issue was the fact that most of the visually impaired women left their homes very early in the morning to go and work (begging) in the city centre. By the time researchers arrived at their homes, some of the women were either rushing to leave or had already left. This affected the number of the visually impaired women in the sample. Future studies may consider visiting women with disabilities both at home and in their work spaces. It would also be important to conduct research on women who are not disabled themselves but have children with disabilities under their care. These women also face complex situations and barriers in accessing social services. The current study did not include such women.

Conclusions and Recommendations

Using the concepts of social suffering and structural violence assists us in understanding how women with disabilities in Zimbabwe found themselves confronted by situations far beyond their control during the COVID-19 pandemic. It is reasonable to conclude from the findings presented that the unique COVID-19 circumstances of lockdown restrictions worsened the already vulnerable existences of women and their families along the axes of class, gender, and disability in Zimbabwe. The unresponsive nature of various institutions which are meant to mainstream the needs of women with disabilities before and during COVID-19 reveals how those very institutions violate the needs and rights of WWDs. Such structural violence intensifies the social suffering of women with disabilities. Our study shows that women with disabilities were largely ignored throughout COVID-19 programming and implementation of COVID-19 measures, and this further exposed them to social exclusion.

The situation of a family member's disability affects the whole family as family members must assist with care and other issues. Therefore, programmes that target assisting WWDs may need to focus beyond the woman herself and seek methods to assist the whole family. Such families face unique obstacles in accessing social services and may require more assistance than is rendered to families without PWDs.

It is recommended that basic services/needs for people with disabilities in general, and women with disabilities in particular, need to be provided by government and local authorities. The COVID-19 pandemic did not necessarily create any new challenges for these poor women with disabilities, it heightened and increased their everyday struggles, some of which had already been 'normalized' as part of the social structure. These issues must be tackled to deal with the inequalities and injustices faced by WWDs.

Professionals working with PWDs must be sensitive to the systemic and institutionalized ableism and its intersections with other forms of oppression (Lund et al., 2020). Inclusive approaches must be deliberately crafted, especially in clinical and public health policy measures (Sabatello et al., 2020). These and other measures could assist in times of crises and pandemics such as COVID-19.

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Data Availability A dataset is available upon request.

Declarations

Ethics Approval The research sought participants' informed consent was approved by the Midlands State University Ethics Board.

Conflict of Interest The authors declare no competing interests.

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