REPORT ON THE AWARENESS RAISING WORKSHOP

HELD AT MADLALA LODGE, BULAWAYO

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1.0 Introduction / Background
The DIWA’s current project is to promote and advocate for the Sexual and Reproductive Health Rights of women and girls with disabilities. The objective of the awareness raising workshop is to raise awareness to the health officials and Civil Society Organizations (CSOs) on issues pertaining to sexual health and reproductive rights of women and girls with disabilities, what challenges they face, how to come up with strategies that will help see more women and girls with disabilities accessing health institutions with dignity and respect. The Project Goal is to contribute to the dignity and respect of women and girls with disabilities in Zimbabwe and Africa by implementation of the UNCRPD. The objective of this awareness raising workshop is to ensure that disabled people are respected patients at health institutions in Bulawayo.

It has been noted that women with disabilities do face challenges ranging from social, cultural, economic, political and structural. This forum created space for women with disabilities to air their challenges and see how best different stakeholders can play their role in addressing these so as see women and girls with disabilities benefitting health-wise.

The Awareness Raising workshop held at Madlala Lodge, Bulawayo, Zimbabwe from the 3rd to the 7th of November, 2014. This workshop brought together representatives from different Civil Society Organisations (CSOs), Disabled Peoples Organisations (DPOs), Disability Activists, Media Houses and Health Officials among others. The workshop was also graced by the Bulawayo Provincial Administrator for Ministry of Women Affairs, Gender and Community Development Mrs. Vaidah Mashangwa and the Disability Activist, Dr. Joshua Malinga. Discussions focused on how to promote the Sexual and Reproductive Health Rights of Women and Girls with disabilities and come up with way forward and recommendations so as to promote the rights of women and girls with disabilities.

This session was chaired by Siphiwe Ncube from Amatshe Aligugu Precious Stones Trust.

1.1 Introductory remarks by the facilitator – Isaac Nyathi
In his remarks, he said that the goal for this conference is not to find faults but to learn from each other and make sure that persons with disabilities feel accepted everywhere even in hospitals. He also pointed out that persons with disabilities at large and women and girls with disabilities in particular should not feel intimidated but accepted by the society. He encouraged participants to be free. He also added that there is need to create a holistic environment where everyone will feel respected and recognised as a human being.

Self-introductions were made.

1.2 Official Welcome Remarks by DIWA Board Member – Nokuthula Ntini
In her welcoming remarks, Mrs Ntini thanked all participants to the awareness raising workshop which was organised by DIWA in collaboration with Amatshe Aligugu Trust. She acknowledged the presence of Zimbabwe Women Lawyers Association (ZWLA), Community Working Group on Health (CWGH), Nurses from Mpilo Hospital, representatives from Zimbabwe Republic Police, Bulawayo City Council Building Section, DPOs representing different types of disabilities and the media. She urged all present to participate in the discussions as this will help forge ahead. She noted that different
organisations were invited as one way of mainstreaming disability within the society, and this development was expected to have more ambassadors at the end of the day, in terms of having more organisations deliberately targeting persons with disabilities in their projects and help also to lobby for disability inclusive policies. Having the media present will enable the widespread awareness raising of SRHR of women and girls with disabilities and to demystify the myths surrounding the sexuality of women and girls with disabilities, said Mrs. Ntini, in ending her remarks.

1.3 Official Opening Remarks the Guest of Honour: Provincial Administrator of Ministry of Women Affairs, Gender and Community Development – Mrs. Vaidah Mashangwa

Mrs Mashangwa commended DIWA for organising a platform that will enable people to share experiences and knowledge on Sexual Reproductive Health Rights (SRHR) for women and girls with disabilities. She noted with pride that Zimbabwe ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in September 2013 and Section 76 and 83 of the Zimbabwe Constitution states that the State must take measures to ensure that persons with disabilities realize their full mental and physical potential including measures to give them access to medical, psychological and functional treatment. For years the needs of persons with disabilities remain unmet especially as it pertains to SRHR. There are serious challenges especially access to essential services and information on sexual and reproductive health. Serious gaps will continue to exist as long as there are no information packs in Braille for HIV and AIDS testing, domestic violence, condom usage, family planning, child care and breast feeding just to mention a few, said Mrs Mashangwa.

She further mentioned that persons with disabilities are more affected by political, social, economic, cultural and structural challenges. Women and girls with disabilities continue to be victims of Gender Based Violence (GBV) and those infected with HIV and AIDS and STIs do not always receive proper treatment when they seek assistance at health centres thereby failing to get the services they want. She went on to say that the 2004 report by Save the Children Norway states that about 87% of girls with disabilities have been sexually abused in Zimbabwe. Approximately 48% of these were mentally challenged, 15.7% had hearing impairment, and 25.3% had visible physical disability. Of those raped 52.4% tested positive for HIV.

She then appealed to the participants and stakeholders that any programming in terms of SRHR has to incorporate women and girls with disabilities because as long as disability issues are not mainstreamed into policies and programmes aimed at improving SRH then efforts of the government in this endeavour will be futile. There is need for stakeholders to work collectively and engage to alleviate problems faced by women with disabilities. Her Ministry is working with hospitals to raise awareness on breast and cervical cancer. She also highlighted that there is need to train public service in Sign Language to bridge the communication gap.

Over the years, her Ministry has funded some women with disabilities’ projects through the Women’s Development Fund. They have also conducted trainings in business management, trade regulations, mining best practices, computer literacy, manufacturing of detergents, floriculture, and poultry production, best farming practices, piggery production and small livestock production. She also informed the participants that the Ministry has come up with
the Girls and Young Women's Empowerment framework, which she offered to share with DIWA.

She ended her speech by informing DIWA that her Ministry is willing to work with DIWA and the rest of other organisations dealing with women and girls with disabilities in empowerment programmes. With these remarks she declared the workshop officially opened. See attached Annex for the detailed presentation.

1.3.1 Comments and / or questions

Following her presentation, the house appreciated her presentation and the good work which her Ministry is doing. But there were sentiments that very little was being done and how to get the government to walk the talk.

In her response, Mrs. Mashangwa advised that lobbying is the answer and proposed that this should be channelled through two Senators, who happen to be persons with disabilities. Also she informed the house that her Ministry has an open door policy, and the Minister is available every Fridays to meet with people.

She also mentioned that some of the Acts have been translated into vernacular and with continuous lobbying the same can be done into Braille.

In response to what the Government has done towards persons with disabilities, Mrs. Mashangwa pointed out that the government has ratified the UNCRPD, have provided social protection among others. The participants agreed to this but called for more work to be done in order to domesticate the UNCRPD, and there is recognition of the social protection approach, and that few milestones have been done. The answer then to all this was need for lobbying the government.

1.4 Workshop objectives and expectations

1.4.1 Objectives

~ Issues on gender mainstreaming and how that can elevate our role in society
~ To know of the disability models so that we can see where we are and be able to engage with various stakeholders to enhance our participation and access the various services
~ Share on some of the UNCRPD articles and those of the national constitution that promote the interests of women
~ Share on the challenges of accessing health institutions, our physical environment as well as the legal processes that contribute to our wellbeing as women
~ To know of the advocacy and lobbying methods that we can use to build an environment that is conducive for women.

1.4.2 Expectations

~ To know how the general public in our society view women with disabilities.
~ To know how to lobby for Sign Language provisions in Courts, Hospitals and schools.
~ To know how to elevate young women with disabilities to bigger models, have a better life and be expected to be represented in all sectors.
To use the right methods to lobby disabled women’s rights.

How will the challenges be overcome? E.g. accessing health institutions, workplaces, etc

Who should monitor gender mainstreaming?

To know how organizations working with disabled people have lobbied the Government to tackle challenges being met by the disabled groups within the health sector. Has this worked? Any success stories?

To have an in-depth knowledge and understanding of disability models and how there are applicable in our own socio-economic environment.

To understand the challenges of accessibility to health institutions.

To learn more on people with disabilities and how to cater for them during service provision.

Appreciate other services being provided by others and networking thereafter.

To understand what UNCRPD in conjunction with Zimbabwe Constitution is doing about disability.

Know more about issues of UNCRPD and the Disability Act and how it can help us as women with disabilities.

How we can put what we learnt in practice in our organizations.

As an organisation working with SRHR issues, I expect to learn how best we can address challenges faced by Youths with Disabilities.

My expectation is that all people who are here today must learn Sign Language as you are aware that is one of the 16 Languages.

To come out with a strategy on how best we can mainstream disability in all stakeholders.

To know my rights (healthy wise) Reproductive Rights and advocate for Rights of women.

Certificates after completion of workshop and modules to take home with so as to continue learning.

How best to deal with ever increasing GBV. And how to reduce cases of rape amongst young disabled people.

Is the Ministry of Health ready to deal with these issues?

I expect to know how I can be accommodated in the environment of non-disabled people and how can we make the community respect us.

To raise the flag high on issues affecting women with disabilities.

Creating good rapport with everyone and be able to interact and understand each other despite different organizations.

2.0 Presentations

2.1 Overview of the SRHR Project by DIWA Coordinator – Xoliso Msebele

In her presentation, she stated that the project goal is to promote and advocate for the Sexual and Reproductive Health Rights of women and girls with disabilities and to demystify the myths surrounding the sexual and reproductive health of women and girls with disabilities through multi-sectoral approach. The project objective is to advocate for the dignity and respect for women and girls with disabilities in Zimbabwe and beyond, with special focus on Sexual and Reproductive Health Rights (SRHR). The project will be targeting Mpilo Hospital as it is a referral centre and 3 other health institutions.
In order to achieve the above objectives, it has planned to conduct a number of activities one of which is the Awareness raising workshop.

The objective of carrying these activities is to:
~ Raise awareness on issues of disabilities;
~ Engage and learn from each other on issues of access, pertaining to disability through the lenses of social model;
~ Come up with ways of how we can domesticate the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which Zimbabwe endorsed in September 2013;
~ To help complement some of the government initiatives through contributing to the training of few health personnel in Sign Language as this is one of the recognised language.

2.2 Disability and Gender mainstreaming – by Isaac Nyathi

Mr. Nyathi took the participants through this session. In his presentation, he started by defining the below terms as follows:

Disability: Long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. UNCRPD

Gender: This is a term that refers to both women and men it is a non-sexist term

Mainstreaming: Mainstreaming a gender (disability) perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes in all areas and levels adapted from United Nations Economic and Social Council ESCOSOC 1997.

Gender equity was described as fair distribution of services and resources.

The presentation was based on the following topics:
~ Consequences of Mainstreaming;
~ What are the challenges faced by women;
~ What do we want to achieve;
~ What is needed to ensure success in mainstreaming women’s issues;
~ Which instruments will underpin our success;
~ Who are our targets; and
~ What is an ideal situation

In this discussion the one of the consequences of mainstreaming was said to eradicate poverty because what will be good for persons with disabilities will be good for everyone. One of the participants concurred with the facilitator that there is need to mainstream disability in all aspects including health as well by giving an example on how she was treated when she had gone to get tested for HIV/AIDS and cervical cancer. The nurses did not know how to assist
Her and she is on a wheelchair. The cervical cancer testing machine is not accessible and she needed to be lifted up to be put on the bed. When they were testing her for HIV/AIDS she was asked questions like why would a person like her want to be tested because persons with disabilities are perceived to be asexual.

Another issue of terminology was deliberated on and it was agreed that people should be addressed by their names not by their disability type. For example there was an article in one of the local newspapers whose heading was titled Chirema chekubhinywa chakafaya. Literal translation, it means a raped disabled person dies. In the Shona language addressing a person using ch is an insult, as it refers to a thing not a human being.

The presentation also highlighted some of the challenges faced by women with disabilities as: Cultural beliefs, access to health, access to education, having a family and a home, sexual abuse and employment.

**Discussion in plenary**

For the effective lobbying of gender and disability mainstreaming the following instruments can be used: The Zimbabwe Constitution articles 76 and 83, the UNCRPD, the Convention on the Rights of Children, the UN Declaration of Universal Rights and the Zimbabwe Disability Act.

It was discussed and agreed that the ideal situation will be:

* Where we are all recognized as part of the diversity in the human species;
* Where access to health facilities is accessible to disabled people;
* Where our right to found a family is respected and accepted;
* Where opportunities for employment are not availed on the basis of physical appearance;
* Where policies are enforceable through sanctions or penalty.

**2.3 Disability models – Sipho Majole**

The presenter started by giving a brief background of her life, and proudly informed the workshop that she was a mother of four children.

The discussion focused much on the four types of disability models and how they view persons with disabilities. The charity model was described as a model that views persons with disabilities as objects of pity and solely dependent on charity because the impression will be they cannot help themselves let alone lead independent lives.

The medical model was described as a model that considers persons with disabilities as persons with physical problems that need to be cured, as such this makes persons with disabilities patients who must be cured to be normal thus rendering persons with disabilities abnormal.

The social model regards persons with disabilities as equal in society and creation of enabling environment thus making persons with disabilities masters of their destiny in that they make their own decisions on how they wish to live their lives.
The rights based model was defined as a model that focuses on the fulfilment of human rights that is the right to equal opportunities and participation in the society. Persons with disabilities often a denial of their basic human rights, education and employment therefore laws and policies should address the denial of these rights.

At the end of the presentation, different views were aired on whether to apply the rights based model have a twin track approach thus social model and rights based model or make use of all the presented approaches. The majority of the participants, however, indicated that it would be better to view disability through the social and rights based model approaches as these models perceive a person with a disability as a human being entitled to full rights like any other person. Debates were around that the fact that social model views that when barriers are removed, persons with disabilities can be independent and equal in society, with choice and control over their own lives. The Human Rights model states that everyone is equal and have rights just like their non-disabled counterparts. As compared to the social and human rights model the medical and charity models. The medical model view persons with disabilities as being dependant and needing to be cured. It promotes the notion that it is the person with a disability who must adapt to the way the society is constructed and organised. The charity model treats persons with disabilities as helpless victims needing care and protection. It relies largely on the goodwill of humanitarians and equality, hence favouring Social and Human rights model.

The following session was chaired by Rejoice Timire from Disabled Women Support Organisation.

3.4 The UNCRPD Article 6 and 25, the new Zimbabwe Constitution Section 76 and 83 and the MDG 5 in the Zimbabwean context: Roles, Value addition, Limitations or Gaps – Chrispen Manyuke

The presentation was made by Xoliso Msebele on behalf of Mr. Manyuke who gave an apology. Mr. Manyuke is the Chairperson of the National Disability Board in Zimbabwe.

3.4.1 The UNCRPD

In his presentation he started by congratulating the government of Zimbabwe for signing and ratifying the UNCRPD. The purpose of the Convention was described as to promote, project and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.

Article 6 Women with disabilities
In his explanation of this article, he described persons with disabilities as among the bottom of the poorest of the poor and the article clearly states that women and girls with disabilities are subjected to multiple discrimination, meaning that they suffer even worse than their male disabled counterparts. He further expounded on this point by saying that in our society today disabled women are not expected to get married and have their own families as they are deemed not capable of carrying out household chores nor raising any children. As a result their parents do not send disabled girls to school as it is considered to be a waste of resources.
Therefore the governments are expected to enact laws that protect these rights and freedoms of girls and women with disabilities. There must be laws on free education for disabled children as affirmative action.

Article 25 - Health
Although this article talks about the right of persons with disabilities to access health, this has not been forthcoming in Zimbabwe. This is witnessed by situations where pregnant disabled women are ridiculed at Health Institutions by health officials on why they have fallen pregnant when they are disabled. There is also urgent need for each health institution in the country to have a sign language interpreter to cater for those with hearing impairments. He gave an example of a man with hearing impairment who nearly lost his life because it was not explained to him that he should come back after 30 days for a new dosage of BP tablets.

3.4.2 The Zimbabwe Constitution

Section 76 - Right to health care
This section talks about the right to health care for every citizen including persons with disabilities.

He further elaborated on this section by saying that whilst this section is generally applicable to any citizen in the country, persons with disabilities should ensure that it covers them because they have been discriminated against in the past and left without any basic health services. He further highlighted that ignorance of the law and constitution is the biggest handicap in this society more so to persons with disabilities as they do not have the opportunity to get any form of education.

Another weakness in section is that it does not say anything about payment for services and affordability.

Section 83 - Rights of persons with disabilities
This section cites that State parties must take appropriate measures, having regard to its available resources to ensure that persons with disabilities realise their full mental and physical potential.

He stressed that the first weakness of this section is that it states that the State carry out these measures only if there are available resources. As a result this gives the State an excuse that it cannot implement because there are no available resources.

He went on to say that most of these provisions are basic human rights but for this section to have meaning and relevance to persons with disabilities there must be allocation of resources by the government.

3.4.3 The Millennium Development Goals
This discussion was mainly focusing on Goal number 5 “Improve maternal health”. The MDGs were initiated at the beginning of the new century in 2000 and they are to be achieved in year 2015. These goals were meant to address issues of the global poor and are all applicable to persons with disabilities as well. This goal looks at the health of the mother. In Zimbabwe prenatal care registration was free at Government until September 2014.
Introduction of these fees has made many women of low income especially women with disabilities which more vulnerable as most of them cannot afford maternity fees. And this risk more cases of maternal mortality increasing as it currently sits on 960 per given 100 000 as at MDG 2012 report.

In his conclusion, he said that because of the lack of political will,(that is taking in the context of section 83) there is therefore need for disabled women’s groups to lobby for the enactment of the disability levy so that a number of programmes relating to persons with disabilities have a source of funding. He urged DPOs to carry out rigorous campaigns to educate society on the rights of women and girls with disabilities and also seek to get workshops to educate their women and girls with disabilities on the provisions on the new constitution including seeking legal consultants who can interpret some of the sections to their members.

Finally he advised the disability fraternity not to let these instruments to gather dust like the Disabled Persons Act of 1992 but rather utilise the opportunity provided by the UNCRPD and seek for legislation that protects them from undue isolation, exclusion and discrimination by both the health institutions and the public as well.

Comments raised were that much more needs to be done in order to walk the talk. It is high time that DPOs and like-minded organisations to work hard in educating their members to know some of these instruments and then this will make more people to stand up and demand for their rights. Referring to the above presentation on the UNCRPD, it was commented that the document clearly spells out the rights of persons with disabilities, and the States are expected to play their role, without any reservations. Change can only happen if those in authority are kept reminded of the same.

With reference to Section 83 of the new Zimbabwe Constitution, this was also a cause for concern, where the State stipulates that it will, depending on the availability of resources. The assumption was that disability was not among the top priority agenda of the country’s development. And of that is the case, then attaining MDGs was then a non starter, domestication of the UNCRPD to remain a pipe dream. See attached Annex for the detailed presentation.

3.5 Promoting Sexual Reproductive Health at Community Level – Happy Magama from Community Working Group on Health

In her presentation, sexual health was defined as ßa state of physical, emotional, mental and social well-being related to sexuality: not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. And reproductive health was defined as ßA state of complete physical, mental and social well-being and not merely the absence of disease, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Therefore, for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. For reproductive health to be attained men and
women should have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy baby.

Components of sexual reproductive health include; maternal and child health, family planning; prevention and management of complications of abortions, HIV/AIDS and STIs, prevention and management of sub-fertility, adolescents' reproductive health, problems of elderly women, women and adolescents with disabilities and gender based violence.

Sexual and reproductive rights include among others:

~ Receiving the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services seek and impart information in relation to sexuality;

~ Receiving sexuality education;

~ Having respect for bodily integrity;

~ Having consensual marriage;

~ Deciding whether or not and when to have children;

~ Pursuing a satisfying, safe and pleasurable sexual life;

~ The responsible exercise of human rights requires that all persons respect the rights of others.

This can only be achieved in the community if we, just to mention a few:

~ Gain support from the local leadership and the community. This helps to shift the ways in which communities deal with sexual health as community adults and leadership are partnered with women and young people with disabilities and with program planners to create appropriate solutions to community problems.

~ Integrate SRH information into Community Based Programs e.g. youth Centers, Church programs, Clubs, Community based students and using these groups can be very cost effective.

~ Using multi approaches to behavior change e.g. negotiating for safe sexual practices and provide them with a condom. Make use of different sources e.g. peers, teachers, parents, sports coaches and other family members.

~ Promoting multi-sectoral action – All CSOs have roles and responsibilities in promoting reproductive health. One of the key actions needed to improve reproductive health is the empowerment of women especially through education.

~ Continuously monitoring and evaluating our SRH programs-data collection methods e.g. surveys and interviews.

She also shared the benefits of promoting SRH at community level in ending her presentation, which included:

Â It provides women and girls with information and skills to behavior change through naturally occurring channels of influence within the community.

Â It fosters the adoption of specific health promoting practices and behaviors amongst women engaged in risky behaviors.

Â It helps sustain newly acquired health promoting behaviors and hopefully solidifies these changes
Â It strengthens Individual-level program effects over extended time periods reducing the potential for relapse to high risky behaviors.
Â It may foster an atmosphere that discourages the initial adoption of health damaging behaviors.

See attached Annex for the detailed presentation.

Discussion in plenary

From her presentation, the workshop participants deduced that there was a need to increase lobbying so as to get laws and public health policies that employ considerable influence on the context and circumstances in which SRH decision making and behavior takes place and to incorporate and understand the effect of society, culture, political and economic forces. By so doing it will be able to promote Health at Community Level and be able to promote the developmental, macro level and societal as well as creating a social environmental that supports community adoption and maintenance of health promotion behaviors.

It was also noted that most of the issues presented called for more support from the community members so as to make a difference. However, it was indicated that sexual health rights were to be enjoyed if all persons get the education on such matters. One of the participants concurred with the sentiments and added that as a growing young lady with a disability, she did not get such knowledge from her family members as they regarded her as ŋumuntu we Nkosi. And she learnt it the hard way.

On the issue of condoms, it was said that these are not friendly to some persons with disabilities, especially the female condom. Firstly, without the Braille mark, it is not easy for women with hearing impairment to tell the expiry date of the product. Every time they want to use the product, they will be forced to rely on their Guides, a scenario which does not promote one’s privacy at all. Secondly, for some disabilities, it is not easy for women to be in the said positions to put on the female condom. This then does not empower such a woman to have her family planning choices as it were and to prevent for STIs and unwanted pregnancies. Sipho Majole informed the Workshop that as a small team, they once approached Health officials on the matter e being taken for granted by the communities and they are awaiting a response from them.

It was agreed that all CSOs have a role to play, but there was need to address the issue of attitude as it leads to discrimination. With the positive attitude from both players, it was said that it was possible for all concerned to support each other and curb the violation of disabled person’s rights.

Lack of disability statistics were mentioned as one of the set Íbacks to development, as these were making it difficult for the government and all development partners to develop disability sensitive budgets. All partners present were requested to devise a system of having disaggregated data including disability as the figures will inform better planning for persons with disabilities across the board.

The following session was chaired by the Daniel Masotsha of Association of the Deaf (ASSOD)
In his opening remarks he concurred with Mr. Manyuke’s presentation, adding that because of lack of information he also lost a wife to BP. After taking her medication for 30 days, they thought that it was the end of the medication course because it was not communicated to them that she was supposed to go report back to hospital for BP check up. By the time they realised that she was not getting better it was already too late and she passed on.

He then invited participants to share their previous day’s lessons learnt and the following was noted:

1. Disability which cannot be cured is called an impairment and that barriers are what makes people with impairments to be disabled;
2. The charity model should be appreciated for being an eye opener which led to most people to fight for their rights as well;
3. Media to portray persons with disabilities positively;
4. Gender and disability mainstreaming is important in all programmes, as well as need for Sign Language;
5. The Disability Act has loop holes therefore there is need to lobby so as to close the gaps;
6. Terminology matters. The society will need to be educated on some of these disability terminology and learn to call people by their names, not by their physical appearance;
7. Knowledge, skills, and services to enable an individual to be informed and be responsible; and
8. Families have a role to play to educate all their children on SRHR issues, regardless of their disability and gender.

3.6 Challenges faced by women and girls with disabilities in accessing SRHR – Zifa Moyo from Zimbabwe Women with Disabilities in Development (ZWIDE)

In her presentation, she mentioned that women and girls with disabilities face massive challenges concerning their health issues. Although as per the UNCRPD and the Zimbabwe Constitution everyone has the right to health but for women and girls with disabilities this right continues to be infringed, socially, culturally, politically, economically, and structurally.

She grouped her challenges under the following factors:

<table>
<thead>
<tr>
<th>Socio-Cultural Factors</th>
<th>Political Factors</th>
<th>Economic Factors</th>
<th>Structural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural beliefs</td>
<td>PWDs not involved in planning and implementation</td>
<td>Lack of financial commitment</td>
<td>Disability unfriendly buildings and equipment</td>
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<tr>
<td>Self-denial</td>
<td>No disability policy</td>
<td>Limited trained health personnel</td>
<td>Poor road networks</td>
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<tr>
<td>Gender roles</td>
<td>Lack of roles and legal framework</td>
<td></td>
<td>Inaccessible transport</td>
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<tr>
<td>Religious issues</td>
<td>Disability Act is outdated</td>
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</table>
It is high time that persons with disabilities should start to network and form partnerships with different stakeholders—disabled or non-disabled because persons with disabilities have been working on their own for a long time. Working together will enable the different stakeholders to know the issues affecting women and girls with disabilities, and in the long run, this is expected to create a conducive environment for everyone, where disability will not be seen or regarded as a sickness or curse. With such a paradigm shift, it will then be easy for disability to be mainstreamed in programmes and projects by the government, corporate world and the community at large.

**Discussion in plenary**

From the above challenges, it was noted that achieving some of these rights was a mammoth task. All technical expertise and skills were called upon in order to address these barriers which were hindrance to the full participation of women with disabilities in accessing SRHR.

Some were still practising harmful cultural beliefs which were disadvantaging a girl child. Different cultural practices were discussed with mixed feelings and at length. It was then suggested and agreed that cultural beliefs do not in a big way support the social model of disability and there is need to desist from practicing such.

Lack of financial commitment, especially on the part of the government was said to be the biggest stumbling block, as the lead to unfriendly infrastructure, lack of trained health personnel in disability issues, lack of user-friendly equipment to cater for persons with disabilities. It was suggested that there is need for lobbying the government so as to invest in persons with disabilities as well.

The problem of limited trained health personnel was also an issue which needed urgent attention. This was mentioned with special focus on training of health personnel on Sign Language and having health information packs on Braille. Reference was made to the above presentation by Mr. Manyuke and Daniel Masotsha’s case. Efforts were then requested from all angles so as to save lives. One of the participants also added that she is living positive with HIV / AIDS. She is living positively because she managed to get information and got assisted like any other. This testimony is a proof that there is need to avail health information to all. If MDG 6 on combating HIV / AIDS is to be zeroed, then, this information should be provided in accessible formats so that all sexual active members of the society can be informed, get enlightened and make sound decisions about their lives.

**3.7 Role Plays**

The aim of the role plays was to highlight the challenges that women with disabilities face in accessing health services due to discrimination and lack of knowledge on the part of health officials on how to assist persons with disabilities and specifically women and girls with disabilities.

**3.7.1 Role play 1 - Challenges in Accessing Health Services**

This was a normal clinic setup where different expecting mothers were there for their antenatal check-ups. From the role play, two mothers without disabilities were friendly assisted. But the service towards the third expecting mother with a disability was different.
She received a discourteous reception. After exchanging words with the Nurse, she then demanded to see the Sister in charge and lodge her complaint.

Lessons Learnt from this role play were:
1. Discrimination is still at play in the society. this is evident by the way an expecting mother with a disability was treated as compared to her non−disabled expecting mothers, who were given a warm reception;
2. Need for people to be empowered as the expecting mother with a disability demonstrated that she knew her rights;
3. Disability is seen as a “special case” yet all expecting mothers are known as special cases. This informed the workshop participants that disability is still seen through the lens of medical model

3.7.2 Role play 2 – Challenges in Accessing Information
In this role play, Community members had attended an Educational Talk on Condom Use. Among the group, two community members had disabilities; thus one with visual impairment and the other one with hearing impairment. The facilitator of the Talk distributed some pamphlets and made some demonstrations. After the Talk the two women with disabilities were left seated on the benches after people were told to go to the next room for more information.

Lessons Learnt from this role play were:
1. Clients with hearing and visual impairment did not gain anything from the Educational talk;
2. Need for Provision of Sign Language to relay information to those in need;
3. Information on Braille is also a prerequisite so as to benefit all members equally. The other clients, resembling the society was also to blame as they failed to engage as well as accommodate one another.

The following session was chaired by Connie Sibanda of Zimbabwe Women with Disabilities in Development (ZWIDE)

3.8 Presentation on Visual Inspection of the Uterine Cervix – by Dorothy Nsangwe from Mpilo Hospital
In her presentation she explained that cervical cancer is now the second most common cancer among women worldwide, accounting for approximately half a million new cases per year and is also the most common cause of death among women. In Zimbabwe, cervical cancer is the most common cancer accounting to 33.4% among women between the 45−49 age groups and the HIV prevalence among this group has been reported to be 43.5%.

Radiation and chemotherapy are not readily available or accessible in Zimbabwe and Bulawayo in particular. About 1286 women die from cervical cancer annually in Zimbabwe. The age standardised mortality rate is estimated at 33.4 per 100 000 women per year and this is more than 4 times the estimated global average of 7.8. With these alarming statistics, she then urged all sexual active members of the society to go for testing as prevention is better than cure. To the surprise of the workshop participants, it was said that a person can stay for 10−20 years without knowing that she has got a cervical cancer. One of the causes of this was said to being sexually active at a tender age. It can be hereditary. As a disease takes such
a long time to be detected, it was then a cause for concern for all active women to go for testing and advised to do regular check ups as advised by the health personnel.

A pictorial presentation was made explaining the stages of cervical cancer and she mentioned that this can be treated if detected at an early stage. When chemotherapy is needed, the service is not for free and in most cases, the fees are beyond the reach of the many. Once it gets onto advanced stage, it is not curable and it can lead to death. She added that cancer is at the present moment rated the second killer disease in Zimbabwe, but this can be reduced if all persons take a responsibility and go for testing.

**Discussion in plenary**

Workshop participants thanked the presenter and were interested to hear if facilities were user friendly to persons with disabilities. She acknowledged that the cervical testing equipment is not accessible to persons with physical disabilities especially those who use wheelchairs. But she assured the Workshop that means will always be available to help all persons seeking such a service, and encouraged people to come in large numbers for testing. She informed the workshop that this (VAC) was a free service to all.

Nokuthula Ntini pointed out that she has visited the testing centre, but the floors are too slippery, making it difficult for persons who use crutches for mobility to manoeuvre. This was said to be a weakness on the part of the Health institution and other stakeholders by not consulting persons with disabilities when for example they are building public buildings. DPOs present assured all service providers and planners that they were available for consultation and possible partnerships so as to create an enabling physical environment for ALL.

Most of the workshop participants displayed displeasure on the issue of having dysfunctional equipment and referring patients to Harare as this worsened the plight of the persons with disabilities who cannot afford to travel due to lack of funds as well as inaccessible transportation. There was then a call for the decentralisation of these services for the benefit of all citizenry.
### 3.9 Group Work

The chair of the Session asked the workshop participants to break into four groups and deliberate on: Gaps in programs that facilitate access to SRH services, SRH counselling programs, in policies and in gender programs, and then report back.

<table>
<thead>
<tr>
<th>GAPS</th>
<th>GROUP 1</th>
<th>GROUP 2</th>
<th>GROUP 3</th>
<th>GROUP 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in programs that facilitate access to SRH services</td>
<td>Information dissemination not accessible e.g. in braille</td>
<td>- Acceptance and attitude</td>
<td>- Access to information - braille and sign language</td>
<td>- No interpreters</td>
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<tr>
<td></td>
<td></td>
<td>- Ethical professionalism in nurses</td>
<td>- Physical access</td>
<td>- No braille</td>
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<tr>
<td></td>
<td></td>
<td>- Individual rights/ freedom of choice</td>
<td>- Staff lack knowledge about disability issues</td>
<td>- Families affected need to be engaged</td>
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<tr>
<td></td>
<td></td>
<td>- Accessibility and availability of services</td>
<td>- Attitude’s unfair treatment/ discrimination</td>
<td>- Accessibility of most buildings is a challenge</td>
</tr>
<tr>
<td>Gaps in SRH counselling programs</td>
<td>- Language barrier</td>
<td>- Breach of confidentiality e.g. trust with interpreters</td>
<td>- Inaccessible infrastructure</td>
<td>- Lack of information</td>
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<td></td>
<td>- Attention of service providers</td>
<td>- Non-existent or irrelevance of</td>
<td>- Negative attitudes by staff towards PWDs</td>
<td>- Affordability of assistive aids e.g. wheelchairs</td>
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<tr>
<td></td>
<td>- No privacy and confidentiality</td>
<td></td>
<td>- Communication barriers (sign language)</td>
<td>- Accessibility to transport</td>
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<td>- Lack of access to family planning methods e.g. female condoms</td>
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<td></td>
<td>- Shortage of material resources</td>
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<td></td>
<td></td>
<td></td>
<td>- Negative attitudes (both nurses and patients)</td>
</tr>
<tr>
<td>Gaps in policies</td>
<td>- No disability policy - UNCRPD not domesticated - Constitution does not define or does not give disability rights</td>
<td>- Specificness in policies e.g. articulate, clearly - Amendment of work policies e.g. disability friendly - Involvement in policy formulation - Audit compliance ï should, clear monitoring, implementation and enforcement of policies</td>
<td>- PWDs are not included in the formulation of policies so that they are able to stand for their rights - Braille and sign language not included in family planning - Consultation of PWDs in policy formulation or amendment - No dual protection alternative provided for disabled women - Disability act of 1992 and other policies need revisiting</td>
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<tr>
<td>Gaps in gender programs</td>
<td>ZimAsset economic empowerment - No disabled person involved - Consultation and research should have been done - Unfair distribution of resources to persons with disabilities - Persons with disabilities were left out of the quarter system</td>
<td>- Girl child always blamed - Women lack empowerment - Equalisation of roles e.g. schooling for girls</td>
<td>- The programs do not mainstream issues of disability e.g. the Zimbabwe gender barometer report does not say much about women with disabilities - Lack of statistical components to prove or show whether women with disabilities are benefitting from different initiatives - Need for mainstreaming (also by the local government) - Limited number of programmes that cater for disabled women - Lack of information</td>
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3.9.1 Solutions to gaps
The following solutions were noted after the above presentations:

1. Government to partner with NGOs regarding research related activities.
2. To have policies which positively discriminate persons with disabilities that is not ambiguous but specific;
3. Train service providers on disability related issues and engage them at different fora;
4. Establish an audit team that reports direct to the president’s office as this initiative will be expected to see issues of disabilities being attended to;
5. Urgent domestication of the UNCRPD that is aligning the policies to the UNCRPD
6. The training programme of police and health officials should be inclusive of disability related issues
7. To engage the media and use them as one of the lobbying tools
8. To have focal persons within all government ministries and departments
9. There is need for statistics therefore the government should make sure that all efforts are made to have the statistics providing gender and disability aspect as this clear database will help the Government planning for persons with disabilities from grassroot to national level;
10. Like minded organisations to be engaged so that they close the information gaps.

The following session was chaired by Phyllis Gororo of National Council of Disabled Persons in Zimbabwe (NCDPZ)

The Chair of the Session welcomed everyone to the third and last day of the workshop. She then asked for the recap of the previous day proceedings, which were noted as following:

1. All policies have gaps with regards to disability inclusive as a result this makes it difficult to hold the government accountable
2. Access to information is a challenge in all sectors including health institutions
3. Cancer is one of the diseases which affects women therefore constant check-ups are encouraged
4. Infrastructure is one of the hindrances especially in government buildings
5. Women with disabilities urged to know their rights
6. Female condoms are not user friendly to women with disabilities as a result, this deprives them of dual protection
7. From the role plays it was learnt that there are still Herod characters within the community
8. Disability is still not being fully understood by the society. This is evident by some of the questions that are posed by non-disabled people when they see an expecting mother with a disability or when one goes for HIV / AIDS testing. Some to tend to ask ÒHow she got pregnant?Ó or ÒWhy are you coming for HIV / AIDS testing?Ó

3.10 Presentation on how to legally handle issues of Sexual Abuse - by Beauty Mtendeleki from Zimbabwe Women Lawyers Association (ZWLA)

ZWLA is an association of women lawyers that was established in 1992 by a group of women who were all lawyers in either private practice, government service or the academia and non-governmental sector. Membership is open to any Zimbabwean female lawyers
based in or out of the country. Female law students can also register to be Associate Members.

ZWLA specialises in the following services:
1. Access to justice;
2. Client attendance;
3. Engaging with the informal justice system;
4. Strategic litigation;
5. Transformative justice; and
6. Constitutional and legislative reforms

They also conduct Mobile Legal Clinics in Tsholotsho, Gwanda and Bulawayo peri-urban Provinces. They also provide Legal Education for free, take the law to the people and also conduct education programmes that target males as well.

In her presentation, she explained Sexual crimes; Rape; Aggravated indecent assault, Indecent assault, Sexual activity with a young person and other crimes. Legally, these are terms are different and their punishments vary from fine to life imprisonment.

If a person, knowingly infect the other with STD or HIV, the punishment is imprisonment up to 20 years. It has been said that women "rape" males. In legal terms, she said this does not exist. But rape is a crime where:

- When a boy 12 and above or man has sexual intercourse with a girl or woman without her consent - Vaginal intercourse or anal intercourse
  - Penis must touch the entrance to vagina does not have to penetrate vagina
  - If he tries to have intercourse but penis does not contact with vagina, it becomes attempted rape.

She ended her presentation by encouraging women with disabilities to report cases of abuse to the police and should be free to go to their offices for assistance. Although the issue of sign language is a challenge, they help each and every woman regardless of their disability.

See attached Annex for the detailed presentation.

**Discussion in plenary**

The above presentation was discussed with mixed feelings, as some participants felt that men are also "raped". It was also noted that some of these words are wrongly by the society. It was also interesting to learn that Aggravated indecent assault were crimes committed by either male or female, involving indecent forced penetration of any part of the body e.g. forced anal sex by a male to another male, forced oral sex, forced penetration with an object. And this was different from Indecent assault where there is no penetration of the victim's body, but this is a sexual activity done without consent such as forced kissing, fondling breasts, buttocks, touching private parts, removing clothes, among others.
A case of a Cowdray Park man with mental illness who is being charged of raping a girl with mental illness was brought for discussion. Beauty advised that there is still more homework to be done in order to know the crust of the matter and see how best the case can be handled.

It was also noted that sexual crimes happen more often, but they go unreported due to lack of knowledge. All present were therefore urged to know some of these rights and help by reporting such cases.

Participants also felt that there is need for ZWLA to continuously educate the public on such matters and provide interpretation, as the law is static.

In closing this session, it was pointed out that in order for the awareness raising on such issues, there will be need to look at the accessibility component in terms of Sign Language and Braille so that the society at large benefits and helps bring the culprits to book.

3.11 Presentation on how to influence change through Advocacy and Lobbying – Dr. Joshua T Malinga

He started his presentation by sharing his life experience, how he rose from being an uneducated disabled village boy to Jairos Jiri, to being a disability rights activist and a politician.

In the past, he recalled that persons with disabilities were called names, perceived as a punishment from God or a curse. Despite a lot of advocacy and lobbying, there is still no access to community services, health services education etc. Persons with disabilities contribute just 1% of the literacy rate in Zimbabwe.

The 1980s saw the development of strong movements for disabled people, emerging from the conditions of charity, discrimination and isolation. Charity does not empower people but believes that persons with disabilities need care. This period also witnessed the promulgation of various instruments, such as the UN International Year of Disabled Persons in 1981, the UN Decade of Disabled Persons (1983-1992), the UN Standard Rules on the Equalisation of Opportunities for disabled People (1993) and the Asian and African Decades of disabled people in subsequent years. These instruments created an environment which was exploited by disabled people to promote the promulgation of laws at national level and that of the CRPD (UN, 2006). Once the UNCRPD is signed it needs to be domesticated and it needs to be adapted in the parliament. The disability movement should stand up with one voice to lobby and advocate for the domestication of the UNCRPD.

Advocacy involves the practical use of knowledge for purposes of social change, largely directed at decision makers, but not exclusively. It is an act of supporting an issue or idea, and the assurance provider or the complainant should be able to act to support that issue being advocated.

The concepts of advocacy and lobbying have been used to help design and implement both long and short term intervention strategies to ensure the inclusion of disability in a range of areas such as socio economic development issues. Advocacy and lobbying have brought to the fore the negative impacts of attitudes, traditional beliefs, institutionalisation and segregated education, and proposed solutions through mainstreaming and inclusion in order
to build equality and respect for human rights. Advocacy and lobbying interventions must be solution-focused and may include national, regional or local campaigns for the inclusion of disabled people from the outset to implementation and evaluation stages.

He ended his presentation by saying that as persons with disabilities it is important to create alliances by networking and creating partnerships that will assist in lobbying for our cause. He encouraged women with disabilities to form a committee that will work the Ministry of Gender so that women with disabilities also benefit from different programmes that are being conducted by the Ministry.

**Discussion in plenary**

From the presentation, it was pointed out that there is need to get support from non disabled persons as the society is made up of disabled and non-disabled persons.

It was raised that there a request be made with some early leaders to have a meeting with DPOs so as to revive the movement and lobby for action. At the moment, the blame was noted on the part of non-disabled activeness of some members and lack of harmony.

It was also noted that change in order for change to happen, there is need to engage with policy makers and develop position papers to cement the lobbying. Also media was said to be one of the effective lobbying tools to make us of.

It was reported also that the current Senators for persons with disabilities will be touring all the provinces and this was one opportunity to make use of by presenting issues of concern to them for further deliberation at parliamentary level.

Forming alliances with other CSOs was suggested as one of the noble ideas to help lobby for disability issues. These alliances will also serve as a tool for mainstreaming disability. For example, the new Zimbabwe Constitution do have some gaps. And these can be understood by many if the legal expertise provides interpretation for such. This will be much easier to handle using the alliance's approach.

The Disabled Persons Act of 1992 is now very irrelevant and is being manned by the wrong department, which was said to be the department of Social Welfare. One way of trying to get things moving it the proper place was to advocate for an Act or Policy which is aligned to the UNCRPD. And then do awareness campaigns so that persons with disabilities know their rights as enshrined in both the Constitution and the UNCRPD and to be well conversant about the Acts and / or Policies surrounding them. This strategy will push the government to act and priorities disability as concerns will be raised from grassroot levels to national levels.

In closing this session, it was agreed that lobbying and advocacy is a process not an event.

**This session was chaired by Idah Dube from Zimbabwe Down Syndrome Association (ZDSA)**
4.0 Lessons Learnt and Way forward

4.1 Lessons learnt
After some deliberations, the following were noted as lessons learnt from the three workshop days:

1. There is need for unity so as to achieve goals;
2. Know and use existing structures as this helps to know which offices to approach for assistance;
3. Collaboration and networking with mainstream organisations so as to raise the disability agenda;
4. Work with the communities because persons with disabilities come from the same communities;
5. Need to be empowered in order to fight for rights of persons with disabilities;
6. Ensure that information is accessible to everyone and made available, as this will enable people to make informed decisions;
7. Let us play a role in lobbying for the domestication of the UNCRPD, as this is not a one man’s match.

4.1 Way forward and Recommendations

1. Nurses training curriculum to include Sign Language among others and this should apply to all government institutions;
2. Community is also to act and be disability oriented and be responsible, where persons with disabilities and non-disabled persons work together for a good cause;
3. Tertiary institutions have disability studies, and there is need for DPOs and relevant stakeholders to lobby for the same initiative within the lower academic institutions as well;
4. Gender and disability mainstreaming is important in all programmes, and once promoted, this will see more persons with disabilities contributing to the society as expected;
5. The disability policy should ensure that the rights of persons with disabilities are included and the constitution must guarantee rights of persons with disabilities;
6. Policies must not be ambiguous, but developed in such a manner that promotes rights for ALL and understood by ALL.

5.0 Closing Remarks and Vote of Thanks

5.1 Closing Remarks
In her closing remarks Rejoice Timire thanked all the participants for attending the workshop and for their active participation. She urged everyone to stand together with one voice and advocate for the rights of persons with disabilities. She thanked the health personnel, CSOs and other stakeholders for availing themselves and hoped that this was a learning curve for everyone present. She also thanked the media for their presence and urged them to report positively on issues concerning persons with disabilities and that they should be mindful of the terms they use as some terms are offensive.

5.2 Vote of thanks
Siphiwe Ncube on behalf of the DPOs also thanked DIWA for organising the awareness raising workshop. This workshop brought together various DPOs and different stakeholders and enabled challenges faced by persons with disabilities to be tabled in an interactive way.
She also appreciated the initiative that was taken by DIWA to grant DPOs the opportunity to co-facilitate at the workshop.

DIWA representative, Nokuthula Ntini thanked Dr. Malinga and all presenters for sharing such valued information, and finally thanked the support of all members present, and hoped that the same spirit of working together will continue so as to raise the disability agenda at all levels. This call is for disabled and non-disabled people in for to have a better society.

Sthabile Nkomo from CONTACT Family Counselling Centre gave a closing prayer.
6.0 Pictures

Mrs V Mashangwa making a presentation

Ms S Mutevedzi stressing a point

Mrs S Majole stressing a point

Ms H Magama making a presentation

Ms Z Moyo making a presentation

One of the Role Plays

Group Work

Mr D Masotsha chairing a session
7.0 Annexes

7.1 Evaluation

~ The presentations were good and a lot was learnt especially the issues of terminology, sexual abuse, cervical cancer, learnt a bit of sign language and there was leverage in discussions but gender roles and sex roles were not really differentiated and there were no hand-outs;

~ The input and group work was excellent;

~ It was an eye opener especially seeing persons with disabilities being independent though the ramp at the reception was not disability friendly;

~ The workshop was well-organized, innovative, progressive, and the staff were friendly;

~ Persons with Disabilities need to be more visible and be able to speak out in order for their issues to be heard

~ The accommodation good, though some rooms were not accessible;

~ There is need for the hotel to address the issue of load shedding by having a generator that covers the whole premises;

~ The food was very good, though the waiters were rather slow, especially during breakfast;

~ Generally, the venue was good and out of town, as this made people to attend workshop and not miss any sessions; but the conference hall was too small and did not have enough ventilation;
7.2 Mrs. V Mashangwa’s Remarks

DISABLED WOMEN IN AFRICA AWARENESS WORKSHOP (DIWA)

Remarks

By Vaidah Mashangwa
Guest of Honour

Madlala Lodge Bulawayo: 4-6 November 2014
May I point out from the onset that stigma and marginalization of people with disabilities has continued in the public and private domain for time immemorial. I am happy that Disabled Women in Africa (DIWA) has organized this workshop so that people share their knowledge and experiences in terms of Sexual and Reproductive Health Rights (SRHR) for women with disabilities. Of course this is just one facet, there is also women with disabilities and education; work, employment; mobility; access to justice; sanitation; land and property rights; marriage; gender based violence and so on.

Zimbabwe has ratified the Convention on the rights of persons with disability and it is imperative that the basic provisions in the Convention be implemented so that everyone is part of the development agenda. Apart from that, the Constitution of Zimbabwe Section 76 and 83 states that the state must take measures to ensure that Persons with disabilities realize their full mental and physical potential including measures to give them access to medical, psychological and functional treatment. People with disability should lobby the government to ensure that the provisions are fully implemented.

For years, the needs of people with disability remain unmet especially as it pertains to Sexual and Reproductive Health Rights (SRHR). There are serious challenges especially access to essential services and information on sexual and reproductive health. Serious gaps will continue to exist as long as there are no information packs in braille for HIV and AIDS testing; domestic violence; condom usage; family planning; child care and breast feeding just to mention but a few.

It is high time that everyone realizes that the problems facing everyone in society be they political, social, economic, cultural and structural also affect people with disability maybe with even more intensity than can ever be imagined.

It therefore means that any programming in terms of sexual and reproductive rights has to incorporate women and girls with disabilities in one way or the other. As long as people with disabilities issues are not mainstreamed into programming and policies aimed at improving sexual and reproductive health then efforts of governments in this endeavour will be futile.

In addition, women with disabilities continue to be victims of gender based violence and those infected with HIV and AIDS and STIs do not receive proper treatment when they seek assistance at health centres thereby failing to get the services they want.

According to a report by Save the Children Norway it is estimated that 87% of girls with disabilities have been sexually abused in Zimbabwe. Approximately 48% of these were mentally challenged, 15.7% had hearing impairment, 25.3% had visible physical disability and of those raped, 52.4% tested positive for HIV.

There is need therefore to have concerted and coordinated efforts by all stakeholders so that the problems faced by women with disability will be dealt with collectively. One major area of concern is breast and cervical cancer, the Ministry is working with hospitals and some female doctors in raising awareness among women and there is need for us to engage in that area so that you also receive that training.
Ladies and gentlemen, there is a dire need to train sign language to officers who work at critical service provision centres such as hospitals, clinics, victim friendly units, government departments so that people with disabilities also get the services they want at the right time and place just like anyone else.

DIWA therefore has a mammoth task ahead to ensure that issues of disability are mainstreamed in all government programs, policy formulation, implementation and evaluation.

May I say that the Ministry of Women Affairs, Gender and Community Development is willing to work with DIWA and the rest of other organizations dealing with women with disabilities in empowerment programs. I am glad that over the years the Ministry has worked with women with disabilities at Freedom House and they also received the Women Development Fund. I feel that this can be spread out to other organizations and women.

The Ministry of Women Affairs Gender and Community Development has over the years through skills development trained women and communities in Business Management, trade regulations, mining best practices, computer literacy, value addition as stipulated in the ZimAsset that is The Zimbabwe Agenda for Sustainable Socio- Economic Transformation, manufacturing of detergents, floriculture, poultry production, best farming practices, piggery production and small livestock production among other trainings. Such trainings ladies and gentlemen can be extended to your organisations or groups.

With these remarks I with the house fruitful deliberations and may I declare this workshop officially opened.

I THANK YOU NDATENDA, NGIYABONGA.
7.3 Presentation by Chrispen Manyuke-Chairman of the Zimbabwe National Disability Board at the AWARENESS RAISING WORKSHOP organised by Disabled Women in Africa (DIWA) in collaboration with Amatshe Aligugu Disabled Women’s Trust held at Madlala Lodge Bulawayo on 4th November 2014.

TOPIC-The UNCRPD Article 6 and 25, The New Zimbabwe Constitution Section76 and 83 and the MDGs in the Zimbabwean context: Roles, Value addition, limitations/Gaps.

Officials from DIWA,
Officials from Amatshe Aligugu,
Ministry Officials here present and
All the invited guests

It is my pleasure to share with you these wide issues which I was asked by DIWA to present at today’s workshop.

I was asked to present sections of UNCRPD, Zimbabwe Constitution and Millennium Development Goals MDGs. I will discuss them in that order.

The UNCRPD
The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was signed and ratified by Zimbabwe on the 23rd September 2013. The main purpose for this convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity. The world has moved away from the charity model of looking at disability to the social model where it is a human rights issue. As Zimbabwe is now a signatory to the UNCRPD the disability fraternity needs to move on and take measures to make Government align its laws and regulations to work in harmony with this convention.

Article 6 of UNCRPD states under the heading:
Women with Disabilities

1. States Parties (Governments) recognize that women and girls with disabilities are subject to multiple discrimination and in this regard shall take measures to ensure the full and equal enjoyment of all human rights and fundamental freedoms.
2. States Parties (Governments) shall take all appropriate measures to ensure the full enjoyment, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Disabled people in general are at the bottom of the poorest of the poor and this article clearly states that women and girls with disabilities are subjected to multiple discrimination, meaning that they suffer even worse than their male disabled counterparts. This is true because in our society today disabled women are not expected to get married and have their own families as they are deemed not capable of carrying out household chores nor raising any children. As a result their parents do not send disabled girls to school as it is considered a waste of resources. This UNCRPD article states that Governments must ensure that disabled girls and women enjoy equal human rights and fundamental freedoms. Governments are therefore expected to enact laws that protect these rights and freedoms of girls and women with disabilities. There must be laws like free education for disabled people as affirmative action.
Disabled women must therefore campaign for enactment of such legislation so that they get education to equip themselves with skills for self-reliance.

Most disabled persons face the first discriminatory attitudes from their parents and guardians. Organisations of disabled women should therefore also carry out rigorous campaigns to educate society on the rights of disabled women.

**Article 25**

*This article talks about HEALTH as follows:*

States Parties (Governments) recognise that persons with disabilities have the right to the enjoyment of highest attainable standard of health without discrimination on the basis of disability. States Parties (Governments) shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health related rehabilitation. In particular, Governments shall:

- Provide persons with disabilities with same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.
- Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.

Provide these health services as close as possible to people’s own communities, including in rural areas.

- Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.
- Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner.
- Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

This article of the UNCRPD talks about the right of persons with disabilities to accessing health facilities like any other person in Zimbabwe. We have witnessed situations where pregnant disabled women are ridiculed at Health institutions by health officials on why they have fallen pregnant when they are disabled. It is as if the disabled women have committed a crime by falling pregnant yet it is the right of every woman to have children and have a family. Some health officials even curse the man who will have made the disabled woman pregnant as he is deemed to be cruel. So we are saying to health officials leave the disabled women who are pregnant alone and stop being unsolicited judges and magistrates. If the disabled women have an issue with the men who made them pregnant they will take it up themselves with the relevant authorities. Do your duties as health officials and treat disabled pregnant women as how you would treat non-disabled pregnant women.

We have also seen those responsible for distribution of STI protective materials like condoms skipping houses or places where disabled people and couples reside because they assume that either disabled persons are sexually inactive or that they do not go out like non-disabled
persons. The truth is that disabled persons are part of society and they are sexually active and some of them are promiscuous as well and need to be equally advised of the dangers involved in having multiple partners. There is also need for instructions on use of medicines to be put in Braille. More often when prescriptions are issued from pharmacies they are not written in Braille also thereby leaving those with visual impairments vulnerable with ignorance on the usage of medicines.

There is urgent need for each health institution in the country to have a sign language interpreter to cater for those with hearing impairments. Recently a man with hearing impairment in Bulawayo nearly lost his life. After visiting a big hospital he was given High Blood pressure tablets to be taken for 30 days but it was not communicated to him that he should come back after the tablets are finished because there was no interpreter. The following month he had to be ferried by ambulance as the BP had shot up because he thought treatment was over after 30 days and was told that if he had delayed by a further one day he would have lapsed into a comma or died. He thought he had completed taking the medication with the 30 tablets he had initially taken.

Disabled persons and their organisations must therefore utilise the opportunity provided by UNCRPD and seek for legislation that protects them from undue isolation, exclusion and discrimination by both health institutions and the public as well.

2. The New Zimbabwe Constitution
The new constitution of Zimbabwe which came into effect in 2013 has at least some provisions that protect and endeavour to empower persons with disabilities.

Section 76 Right to Health Care
This section talks about right to health care for every citizen including persons with disabilities under the following provisions:

~ Every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services, including reproductive health.
~ Every person living with chronic (serious) illness has the right to basic health for the illness.
~ No person may be refused emergency medical treatment in any health-care institution.
~ Whilst this section is generally applicable to any citizen in the country, disabled persons should ensure it covers them in particular as they have been discriminated against in the past and left without any basic health services. Ignorance of the law and the constitution is the biggest handicap in our society and more so that most disabled persons have not had the opportunity to get any form of education.

This section has a weakness in that it does not state about payment for services and affordability.

Disabled persons and their organisations must seek to get workshops to educate their constituencies on the provisions of the new constitution including seeking legal consultants who can interpret some of the sections to their members.

Section 83 Rights of persons with disabilities
This section states that:
The State must take appropriate measures, having regard to its available resources, to ensure that persons with disabilities realise their full mental and physical potential, including measures:

- To enable them to be self-reliant, live with their families and participate in social and creative activities;
- To protect them from all forms of exploitation and abuse;
- To give them access to medical and psychological treatment; and
- To provide special facilities for their education.

The first weakness of this section is that it states that the State can carry out these provisions only if there are available resources. This gives the State excuse that it cannot implement because there are no available resources. Disabled people must challenge this section because resources must be allocated to cater for their needs as nothing can ever be implemented with such retrogressive phrases. Most of these provisions are basic human rights like special facilities for education, self-reliant measures and protection from abuse and exploitation. For this section to have meaning and relevance to disabled people there must be allocation of resources by Government.

3. The Millennium Development Goals

The Millennium Development Goals were initiated at the beginning of the new century in year 2000. Eight goals to be achieved by 2015 were developed and were as follows:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal Health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

These goals were meant to address issues of the global poor and are all applicable to disabled persons in general and disabled women in particular because as stated earlier disabled persons are amongst the poorest of the poor.

At this workshop we would like to look at Goal 5 of the MDGs which looks at Improving Maternal Health. This goal looks at the health of the mother. Women carry a heavy responsibility of procreation as they carry the baby for 9 months in most cases before the child is born. At times the baby is not born naturally and the mother has to undergo a caesarean operation which can cost the lives of both mother and child. As a result the health of the mother is of utmost importance. From the start of pregnancy the mother must be registered at a health institution so that she is regularly checked to ensure that the baby and the mother are healthy. In Zimbabwe prenatal registration was free at Government hospitals till two months ago when fees ranging from $30 to $50 are now payable for registering a pregnancy. Introduction of these fees has made many women of lower income groups including disabled women very vulnerable as most of them cannot afford the maternity fees. Disability groups must lobby Government so that disabled people can get this facility for free. Because of their role in procreation some women have developed cervical and breast cancers whose treatment is expensive as some would need chemotherapy. This goal in the MDGs cannot be achieved unless women are accorded free medical attention.

4. Conclusion
In the Zimbabwean context as a lot of funds are required for implementing certain legislation and measures that would alleviate the situation of the disabled woman whilst Government can only implement if there are adequate resources. Disabled Women and their organisations should lobby for the enactment of a Disability Levy so that a number of programmes relating to disabled people have a source of funding. Funding for disability issues cannot be left to philanthropists and well-wishers anymore.

Finally the disability fraternity should not let these instruments now available to them namely the UNCRPD and the new Zimbabwe constitution gather dust in shelves like what has happened with the Disabled Persons Act of 1992 where very little was achieved or/and implemented. They must embark on nationwide campaigns and workshops to educate their constituencies and other stakeholders on their rights and obligations as enshrined in these legal instruments.

The time to lobby and act is now.

Thank you.
7.4 Presentation by H Magama from Community Working Group on Health

1/23/2015

Promoting Sexual Reproductive Health at Community Level

Happy Magama

Reproductive Health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right. It is essential for the full development of human potentialities and for the well-being of the individual and of society. The attainment of this goal requires a change in the status of women in society and the prevention and reduction of diseases and disabilities. It is also important to ensure that sexual and reproductive health is achieved by all. Sexual and reproductive health requires a positive and responsible approach to sexuality and sexual relationships, as well as the possibility of choosing desirable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be recognized, appreciated and upheld. (World Health Organization, Draft Working Definition, October 2010)

Sexual Reproductive Health

- Sexual Health
  - A state of physical, mental and social well-being related to sexuality and the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of choosing desirable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be recognized, appreciated and upheld. (World Health Organization, Draft Working Definition, October 2010)

Components of Sexual Reproductive Health

- Maternal and Child Health
- Family Planning
- Prevention and Management of Complications of abortions
- STI/HIV/AIDS
- Prevention and Management of sexually transmitted infections
- Adolescents Reproductive Health
- Problems of elderly women
- Women and adolescents with disabilities
- Gender Based Violence
In other words,

- Sexual Reproductive health is central to the
- Physical, emotional health and well-being of individuals, couples and
  families, and
- Contributes effectively to the social and economic development of
  communities and countries.

- Sexual health, when observed positively, incorporates
- the rights of all persons to have the knowledge and opportunity to
  pursue a safe and healthy sexual life.

Promoting Sexual Reproductive Health

- In order to ensure that people attain the highest possible level of sexual
  reproductive health and increase awareness, we need to utilise different
  programmatic approaches that will reach out to our intended audience i.e.
  women and adolescents.
- Require us to involve the individuals at community level where we can also
  begin to assess the factors that can prevent individuals from accessing the
  highest possible sexual health.

Sexual and Reproductive Rights

- Explores human rights that are already recognized in various laws, international
  documents, etc.
- Promote sexual health information and awareness.
- Provide women and girls free and accessible reproductive services
- Ensure the highest attainable standard of health in relation to sexuality, including
  providing sex education, reproductive health services, and healthy sexual
  relationships
- Provide sexual education
- Protect all individuals including women and girls
- Respect reproductive rights
- Respect the right to have children
- Respect to safety, health and pleasure in sexual life
- Respect to autonomy, rights and voluntary informed decision-making
  rights of persons respecting the rights
  of infancy
  ( adapted from WHO guidelines, Draft Working Document, October 2002)

How can this be done?

Community Level approaches and interventions
What are they?

- Interventions intended to reduce a risk of a community
- Directly or indirectly influence the knowledge, attitudes, norms, or behaviors of individuals in the targeted community
- Provide the interventions where institutions of the targeted community are likely to be and
- Deliver the intervention broadly and sustain community members.

How can this be achieved in our community?

- Gain support from the local leadership and the community; review the risks and responsibilities of community members
- Allow them to diagnose the issues in their community and to activate ongoing changing, implementing, and reducing strategies to address the problem.
- This helps shift the ways in which communities deal with sexual health and reproductive health in order to ensure that everyone is partners with women and young girls.
- Work in partnership to create appropriate solutions to community problems.

CONT'D

- Promoting multi-sectoral action: Sexual reproductive health is a health issue that transcends more than biological aspects and goes beyond the health sector. The development of Sexual Reproductive Health is a shared responsibility among the government, and it requires the involvement of various stakeholders. The stakeholders include policymakers, educators, health workers, faith leaders, and community leaders. By working together, we can address the sexual reproductive health challenges in our community.
- It is important to ensure that women and girls have access to quality health services, education, and opportunities to participate in decision-making processes. This can be achieved by providing resources and support to organizations that work towards these goals.
- Continuously monitoring and evaluating our SRH programs and collection methods (e.g., surveys and interviews).
Promoting Sexual Reproductive Health

- For sexual reproductive health to be promoted effectively, an individual and the communities need to be aware of the determinants and the role to address these issues.
- Education
- Society and culture
- Economics
- Health systems and Services

Economical

- Poor, marginalized communities have poorer sexual health outcomes.
- Poor sexual health can contribute to poverty (by limited earning potential and being forced to spend on health care)
- Poverty is closely correlated to participation in sex work and transactional sex
- In many settings, participation in sex work and transactional sex is associated with poorer health outcomes.

Society and Culture

- In the community level, recognizing the social and cultural context means being aware of the norms, health and practices of any one community and the role that various health systems and policies have in reinforcing or challenging the views of the community.
- Family and community are double-edged
- Discrimination (power and information, gender based violence, incest)
- Promote sexual health, literacy, information, respect, acceptance, awareness of services
- Religious and cultural values
- Enhance vulnerability (plural of sensitive information, vulnerabilities)
- Promote sexual health (promoting service access, tackling gender based violence)

Laws and Policies

- International conventions (e.g. CRC) and consensus statements (e.g. KDSP, MDG) can provide a supportive environment for sexual health
- Local laws and policy frameworks can
  - omit/due laws which criminalize sex outside of marriage or are otherwise unenforceable
  - recognize the (e.g., legal, cultural, gender roles, etc.)
- The attainment of sexual health goals are
- Laws and policies can help reduce stigma and discrimination (e.g., ZNAPC Policies)
Community Health System and Services

- Services should
- Be available to all regardless of age, sex, sexuality, marital status
- Be provided in confidential, private and non-discriminatory way
- Include identification and referral for victims of sexual and other forms of violence
- Include voluntary counseling and testing for HIV
- Offer access to all contraceptive methods, and prevent and promote preventive health education
- Diagnose and treat for sexual dysfunction
- Diagnose and treat for HIV, reproductive cancers and associated infertility

In Conclusion.

- There is a need to increase knowledge/knowledge and skills in behavior change through capacity-building of healthcare workers in the community
- Increase the adoption of wellness-promoting behaviors and reduce the prevalence of risk behavior
- Women and men who marries health-promoting behaviors and positively influence behavior
- Strengthen behavioral change process affecting awareness and control reducing the potential for relapse to high-risk behavior
- May foster an atmosphere that encourages the initial adoption of health-promoting behaviors

Benefits of Promoting SRH at Community Level

- Providing awareness and information, leading to behavior change through capacity-building of healthcare workers in the community
- Increase the adoption of wellness-promoting behaviors and reduce the prevalence of risk behavior
- Women and men who marries health-promoting behaviors and positively influence behavior
- Strengthen behavioral change process affecting awareness and control reducing the potential for relapse to high-risk behavior
- May foster an atmosphere that encourages the initial adoption of health-promoting behaviors
7.5 Annex 5

SEXUAL CRIMES

Definition of sexual crimes
- Sexual activities against law because none of the persons
- Has been forced
- Is not legally able to give consent e.g. young person
- Prohibited degree of relationship – incest
- Activity may lead to spread of HIV

rape
- When boy 12 and above/ man has sexual intercourse with a girl or woman without her consent
- Vaginal intercourse or anal
- Penis must touch the entrance to vagina does not have to penetrate vagina
- If he tries to have intercourse but penis does not contact with vagina it becomes: interrupted rape
- Assisting a person to commit rape – convicted as an accomplice
- Punishment: life imprisonment or shorter
- Court also considers trauma suffered, STI, HIV infection, age of victim

Aggravated indecent assault
- Crime can be committed by either male or female
- Involves indecent forced penetration of any part of the body e.g. forced anal sex by a male to another male, forced oral sex, forced penetration with an object
- If boy is between 12 – 11yrs is penetrated without consent by adult male its aggravated indecent assault
- Punishment same as rape
### Indecent assault
- Sexual activities done without consent such as forced kissing, fondling breasts, buttocks, touching private parts, removing clothing
- No penetration of the victim's body
- Punishment maybe a fine or imprisonment

### Sexual activity with a young person
- A girl below 12 not capable of consenting to sex even if she consents the male charged with rape
- 12 – 14 yrs girl incapable of consenting if proved she consented the boy/man is charged with sexual intercourse with a minor
- Punishment life imprisonment or shorter

### Spreading STDs or HIV
- KNOWLINGLY SPREADING HIV/STD
- Imprisonment of up to 20 years

### Other crimes
- Sexual activity with mentally incompetent person
- Sex within prohibited degree (inced) – relationship between first and second cousins now included
- Sodomy – physical contact of a sexual nature between males
- Bestiality
- Public indecency & obscene language, indecent songs, writing or drawings, exposing one's body in public, urinating in public
- Prostitution/pimping
- Punishment imprisonment for a year