Disability is not asexuality: the childbearing experiences and aspirations of women with disability in Zimbabwe

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Abstract: The aim of this article is to elucidate the childbearing experiences and aspirations of women with disability in Zimbabwe. The paper draws from a qualitative narrative study conducted by researchers at the University of Cape Town, South Africa, which explored the experiences of sexuality of disabled women in Zimbabwe and which used the Biographic Narrative Interpretive Method to generate data. In part, the study revealed that disabled women often encounter a diverse range of challenges that are associated with disability and which hinder them from realising their full sexual and reproductive health and rights. Some participants recounted that they are happy with the fact that they have their own biological children, albeit registering frustration with the fact that they are in most cases discriminated against both within and outside of reproductive healthcare centres. Participants who had not had any childbearing experiences by the time of the study reported that they aspired to have their own biological children. Whichever way, the women's narratives are challenging the myth that women with disability do not require space in the childbearing arena because they are disabled. DOI: 10.1080/09688080.2017.1331684

Keywords: disabled women, childbearing, sexual and reproductive health, Zimbabwe, biological children

Introduction

On a global scale, women with disability rank among the most discriminated against minority groups, hence it is not surprising that their experiences of childbearing and early motherhood have largely been ignored, resulting in a paucity of international and local studies on the subject. A study carried out by Thomas in the UK revealed that the reproductive experiences, desires and choices of women with disability are embedded with further concerns arising from the marginalisation they encounter in their personal experiences of living with impairment. In South Africa, Mgwili and Watermeyer researched on the discrimination of women with physical disability within state reproductive health clinics and noted that the message that is commonly conveyed either blatantly or covertly is that the women have no place in the realm of sexuality, which includes childbearing, because they are disabled.

That is not to say that negative attitudes of healthcare professionals are a major barrier to accessing appropriate reproductive healthcare for women with disability alone; but women without disability may also be affected. Nevertheless, such attitudes may further marginalise women with disability, given that a number of healthcare professionals often assume that people with disability are sick persons who should only consult healthcare centres for illnesses that are related to disability. Yet, persons with disability have every right to consult healthcare institutions for reasons which may not necessarily be disability related, such as access to contraceptives or for pregnancy related issues. Nevertheless, according to Thomas, women with disability are discriminated against from the onset of pregnancy right through to motherhood.

A huge number of women with disability express anger about the inability of healthcare staff to provide them with appropriate sexual and reproductive health information and services. Historically, many nations have had laws that prohibit persons with disability from bearing children, among them being Germany, which in 1933 enacted the Law for the Prevention of Genetically Diseased Offspring which permitted forced

Supplemental data for this article can be accessed at https://doi.org/10.1080/09688080.2017.1331684.
sterilisation of anyone who had epilepsy, schizophrenia, mental impairment, genetic visual impairment, hereditary deafness or manic depression. In the United States, Harry Laughlin’s 1914 Model Eugenical Sterilization Law permitted forced sterilisation of persons who had mental impairment or who were deaf or blind. Whilst such laws have since been phased out, some people still believe that all women with disability will give birth to disabled children and yet the reality is that most forms of disability are non-hereditary. Nevertheless, the World Report on Disability marks a turning point in the way in which the concept of disability should be understood, particularly by healthcare professionals. The report calls for a paradigm shift in which all levels of healthcare systems should be inclusive of persons with disability so as to reduce inequalities, including in sexual and reproductive healthcare. Furthermore, the report states that a diverse approach which seeks to overcome physical, communication and information barriers should be employed and alternative models of delivering healthcare services should be explored. The failure of health programmes to embrace persons with disability as full sexual subjects, who among other things have a place in childbearing, runs the risk of undermining their health and well-being.

This paper draws direct quotes from the narratives of women with disability in Zimbabwe, which best exemplify the women’s childbearing experiences and aspirations. The article is located within a critical feminist disability studies (FDS) theoretical framework, which seeks to understand disability from a gender point of view following the mainstream feminist marginalisation of disabled women’s experiences. Several disabled feminist advocates in the Global North contested the masculine structure of both disability studies and the disability movement, in which the voice of women with disability has been evidently missing. FDS scholars argued that the experiences of disabled women may differ in relation to issues such as menstruation, reproduction, abortion, child-rearing and sterilisation among others. The FDS lens also encompasses key tenets of intersectionality, thereby stating that disability is always intimately connected to other identity markers such as gender, culture and class in framing the experiences of women with disability.

Methodology

Similar to the methodological approach articulated in Peta, McKenzie, Kathard and Africa, this study used the qualitative narrative approach. Such an approach was chosen, because as postulated by Clandinin & Caine, it is a way through which people can make meaning or understand experience through conversation, dialogue and the researcher’s ongoing participation in the life worlds of the participants. The methodology
enabled the study to accomplish its objective of articulating the experiences of sexuality of women with disability in Zimbabwe, from which this paper draws the childbearing experiences and aspirations of the women.

The snowball sampling approach was used to draw 16 participants from Harare (the capital city of Zimbabwe), who are aged between 18 and 65 for the broad study, in a context where persons who are under the age of 18 are below the legal age of majority, and above 65 is elderly. Within that age range were women of the reproductive age group whose narratives in part spoke to the topic of this paper. Considering that there is a diverse range of disabilities which according to the UN Convention on the Rights of Persons with Disabilities (CRPD, 2008) includes mental, physical and sensory disabilities, the sample for this study drew women with all kinds of disabilities (see supplemental data for biographic details of participants).

Under the qualitative narrative approach, the Biographic Narrative Interpretive Method (BNIM), which consists of three sub-sessions, was used to generate data. In contrast to semi-structured interviews that are greatly directed, BNIM was chosen because it addresses the hierarchical power relations of research by awarding the participant the power to narrate her story in the way that she wants and to end the interview at her own time, when she feels she has said everything that she may want to say. BNIM does not generate data in a one-off interview but it allows continuous interaction of the researcher and participant through its techniques which encompass three sub-sessions. In the first sub-session, the researcher asks a single question which relates to the topic of the study thereby instigating the participant to narrate her whole life story.

Following a break of an average of 10 minutes for each participant, the researcher in sub-session 2 asks questions which are related to particular incidents that would have been reported by the participant in sub-session 1, to generate rich data. Sub-session 3 is used to clarify obscure points and to gather more biographic data on a different day and after at least a week following the first two sub-sessions. In this study, sub-session 3 occurred after periods of between one week and eight weeks and all participants readily accepted to be interviewed again. All participants described the interviews as a great opportunity to talk about a subject which they regard as one of the most important in their lives, but which no other researcher had previously given them a platform to discuss.

Data analysis
The narrative analysis and the analysis of narratives approaches were the primary data analysis techniques that were used in this study. As postulated by Polkinghorne, a narrative analysis approach results in the formulation of whole life stories, whereas an analysis of narratives approach produces themes that draw similarities and differences from the stories. In this study themes were drawn from the stories that were told by participants. Some stories were told in Shona (vernacular), others in English and others in both Shona and English. Because the researcher uses both languages, no difficulties were experienced with translation from Shona to English. Borrowing practice from Braun and Clarke, after reading and re-reading the data and noting down preliminary ideas, the researcher separated words and sentences across the narrative texts in a process of manually coding the data. By identifying common patterns, codes were collated into possible themes, putting together all data that is pertinent to each possible theme. Names and details of each theme continued to be improved on, to make them more meaningful and clearer, as well as to improve on the whole story that the analysis would tell. However, this paper does not present all the themes that emerged from the analysis because such a presentation would take this article beyond its requirements in relation to both its focus and length.

Ethical approval
After obtaining ethical approval from the University of Cape Town (UCT), (581/2013) and from the Medical Research Council of Zimbabwe (MRCZ), (MRCZ/B/1789), both vernacular (Shona) and English languages were used to obtain informed consent depending on the language choices that were made by the participants. However, to cater for blind participants, the informed consent form and information sheet were translated to Braille and a sign language interpreter was used to communicate with deaf participants. Pseudonyms were used to protect the identity of participants and names of places that could link participants to raw data were withheld.
Findings

The findings of this study show that all women with disability who have had the experience of giving birth to a child or children faced immense challenges in childbearing. The example of Rudo that I present below draws some excerpts from her narrative in Peta.18 Rudo lives on her own in an urban area, and in some instances she stays in her rural home, she is deaf, partially blind, divorced, childless, 50 years old and formally unemployed. She said:

“All my babies died because the doctors and nurses could not use sign language. At first I went to a rural hospital and I lost a baby girl, I was trying to talk to the staff in the delivery ward and they could not hear anything. I could read the nurse’s lips and I saw that she was saying Push! Push! Push! But I couldn’t tell her anything because she did not understand sign language … I think they are not taught in their school how to speak sign language, so they are not educated … my baby girl died …”

Rudo reportedly felt that the inability of healthcare staff to use sign language was perhaps because the professionals were located in a rural hospital. So when she conceived again the following year, and when it was time for her to deliver her baby, she avoided the rural hospital, believing she would get better service at an urban hospital. She said:

“I got to the delivery ward in the city hospital. The senior doctor started to wear his gloves and he opened my legs … there was one senior doctor and eight student doctors, imagine all those people looking at my underneath … I started to feel like they were making me an experiment because I am deaf … they were all wearing white dustcoats and they had notebooks and pens for writing notes. I was in pain … I wanted help, so that I deliver my baby and go home … Again my baby died, it was a big baby boy, 3.5kgs. I think my baby died because they could not speak sign language … surely they are not educated.”

Literature from the Global North states that professional incapacities may create barriers for a deaf person in the hearing world.19 Communication barriers increase feelings of discomfort and humiliation which can be curtailed by the implementation of practices that ensure the inclusion of neglected populations so that their silent voices can be facilitated and heard,20 within sexual and reproductive healthcare delivery systems. Rudo attributes the loss of her two babies during separate child delivery processes to the fact that healthcare staff who attended to her could not use sign language. Although there could be other reasons why Rudo lost her babies, it appears that she is not privy to such reasons because healthcare staff were unable to communicate with her in the appropriate language; she attributes the scenario to a lack of education on the part of staff.

However, it may not be practical for the Ministry of Health and Childcare in Zimbabwe, to train all healthcare staff to use sign language or to position a sign language interpreter at every work shift in anticipation of the arrival of a deaf woman. Nevertheless, in a quest to promote the realisation of the sexual and reproductive health rights of women with disability, the introduction of the concept of birth companions who use sign language could make a positive difference, thereby reducing the distress of the women in delivery wards. Such companions could be family or community members who are trusted by the woman to facilitate communication, and to provide support and re-assurance throughout the child delivery process. Although there is a paucity of literature on birth companions for women with disability, the literature that is available about such companions for other minority groups such as female prisoners21 shows better outcomes that arise from the emotional and practical support that is provided by the companions.

Another example of communication barriers is evident in the narrative of Saru. Previously residing in her rural village and now living in an urban area with her mother, she is 32 years old, divorced, has one 6-year-old son and she is formally unemployed. She said:

“My baby is alive, but the babies of some of my deaf friends have died because no one teaches deaf women to take care of the baby, we are disliked and ignored … I was lucky because at Kuwadzana 4 clinic there was a nurse who has two deaf children so she helped me to deliver my baby. But even this nurse, she only helped me to deliver, but she did not tell me how to take care of the baby but I am happy that I figured it all out on my own.”

The above narrative indicates that in the context of this study, the presence of sign language-using staff in maternity wards may not be a strategically planned and implemented arrangement, thereby creating what may appear to be an attitude of
indifference on the part of healthcare staff. The issue of birth companions that has been previously discussed could therefore go a long way in promoting the realisation of sexual and reproductive health rights and particularly for women with disability. Professional healthcare support should not abruptly end when the baby is delivered, but there is need to provide information about infant feeding and other aspects of early motherhood particularly for first-time mothers.22

The narrative of Saru also brings to the fore aspects of self-stigmatisation on the grounds of disability; she believes that she and her deaf friends are denied information on early motherhood because they are deaf. But as stated by Horton,4 accessing appropriate health information and services for both persons with disability and persons without disability maybe a challenge, owing to the negative attitudes of healthcare staff; all women may refrain from complaining, for fear of victimisation. However, such conservative attitudes towards sexual and reproductive health rights for all women exacerbate unprofessional responses to women with disability.

Another example is that of 31-year-old Mako, who has epilepsy; coming from the rural areas where she was living with her grandmother, she now lives in an urban area with her mother, is a divorced mother of two sons and is formally unemployed. She said:

“When I was 17 years old, I met a boyfriend, Tapiwa, who was older than me and working in town. One day I was in epilepsy absencea, and I went to his office and he had sex with me, without me knowing it. He came to our house on another day and told me about the sex. After four months I discovered that I was pregnant. Ndakabva ndatotizira ipapo ipapo [I immediately eloped to Tapiwa’s place of residence] because you know in our culture they say a man who impregnates you must become your husband. I started to have seizures and the clinic people shouted at me and said: ‘why were you getting pregnant did you not know that you have epilepsy, that is the problem of disabled people, you just come here to give us additional work, is it our fault that you have evil spirits and witchcraft’…”

A key argument of FDS is that disability is a social construction in which standard practices in society fail to embrace disability as human diversity, but instead relegate disability to a category of inferiority.23 The belief of most people is that every person should be able bodied, thereby constructing disabled people as “damaged beings” who are generally ignored and treated as sub-standard. The above narrative indicates an attitude of healthcare staff which seeks to deny women with disability space in reproductive healthcare, on the grounds that the women are disabled and are hence an inconvenience. As noted in the introductory section of this paper, a number of healthcare professionals assume that people with disability are sick persons who should only consult healthcare centres for issues relating to disability.3

Mako’s narrative also shows that the popular cultural understanding of disability, which associates disability with evil spirits, taboos and witchcraft, may be taken into contemporary reproductive healthcare centres by staff, as culture, gender and disability intersect to frame the discrimination against women with disability. As will be further discussed in the conclusion of this paper, there is need for formal disability training and awareness raising which reduces the negative impact of traditional practices on the health and well-being of women with disability. However, care should be taken not to undermine all traditional beliefs, given the fact that some traditional practices may be used in a beneficial way to promote sexual and reproductive health rights, whilst other traditional practices that are harmful should be discouraged. In addition, it is wise for healthcare staff to take heed of the advice given by Mall and Swartz3 who state that clinicians should consider their own cultural and religious values and reflect on how such values or belief systems could impact the ways in which they deliver healthcare services to persons with disability, in an effort to reduce or eliminate unprofessional responses.

To make matters worse and in a move which was meant to frustrate Mako, Tapiwa went and married a non-disabled woman with whom he had previously sired a child. He brought the woman to his house, to live together with him and Mako. She said:

“Tapiwa said to me, ‘I can’t marry you because you are an ill person who has evil spirits, how can I marry a woman who has epilepsy.’ He said my seizures were caused by ‘my’ witchcraft and evil spirits, and that’s why he had decided to marry a non-disabled woman. He also said that he regretted having sex with me because he was afraid that I was going
to give birth to a child who has epilepsy, but you see now my son is 21 years old and he does not have epilepsy.”

From a FDS viewpoint, Mako’s narrative resonates with the assertion made by Garland-Thomson, which states that disability symbolises a construction of an identity by those who consider themselves to be “normal” enough in relation to their bodily features. Such people assume they can take authoritative positions and wield the power that such positions award them to frame what they call a “normal” human being. Such practices often serve to silence the voice of women with disability who are then regarded as “abnormal”. People may try as much as they can to avoid the possibility of giving birth to a child with disability, and in the event that it happens, parents may feel guilty for being irresponsible and “unfair” to the child. However, as previously mentioned and in concurrence with Mako’s narrative above, the reality is that most forms of disability are non-hereditary.

The findings of this study also show a lack of support of women with disability in reproductive health clinics, in relation to issues of contraceptives. For example, Mako narrated that in the seventh month of her pregnancy, she prematurely delivered a baby boy. Tapiwa continued to demand sex from her, despite the fact that he was also being sexually intimate with his wife in the presence of Mako. She said:

“I had a pre-term baby boy at seven months in 2000. I think it’s because I was having severe seizures. After three months I got pregnant again, we were two women with one man, he was demanding sex from me but he was also having sex with the other woman in my presence. The nurses had not told me about the problem of epilepsy drugs and contraceptives; epilepsy medicine weakens the power of general contraceptives to avoid pregnancy, I lost this second baby when I was three months pregnant. I fell very sick and I almost died, and that’s when the clinic staff told me about the problem of the contraceptives and the medicine for epilepsy.”

A study carried out by Mgwili and Watermeyer in South Africa, asserted that family planning clinics

“… are settings which function primarily as a dispensary for various forms of contraception, including oral and injected contraceptives, and contraceptive loops. Before a service user is given contraceptives a thorough medical examination is performed, including an examination of the reproduction organs.”

Contrary to such practice, it is evident that Mako may not have been subjected to such a medical examination but she may have been given contraceptives in accordance with blanket mainstream practices. There is therefore evidence that whilst access to sexual and reproductive health information may be a problem for both disabled and non-disabled women, disability makes a difference in the sense that whilst generic healthcare approaches may apply to all women, women with disability may need unique reproductive healthcare which is tailor-made to suit specific impairments.

Asch and Fine reiterate the fact that some healthcare staff may be ignorant of the negative impact of birth control medical drugs for women with particular forms of disability; such staff may prescribe contraceptives which are detrimental to the health and well-being of women with disability. Drawing from a medical study carried out in Canada by Basson, one can argue that the side effects of drugs, and investigations into sexuality functioning, are significant elements that need to be carefully attended to by healthcare professionals who interact with disabled women. However, a study carried out by Thomas in the UK revealed that women with disability often encounter oppression in healthcare centres in a myriad of ways that may be detrimental to their health and well-being.

Another example, which shows that women with disability may be denied access to sexual and reproductive health information, is that of Danai who has albinism and partial visual impairment. She is 37 years old, and lives in an urban area where she cohabits with her boyfriend of 10 years. She has three children, has never been married and is formally employed as a government primary school teacher. She said:

“… when I went to deliver my first baby I was only 17 years old. I didn’t know how the baby was going to come out of my body. I was thinking that a hole will open on my stomach and the baby will come out through that hole. I just didn’t know a lot of things, because my mother was not telling me. I think my mother was thinking that I am just a useless albino girl who cannot get pregnant; the clinic was also telling me nothing; that is what happens when one has albinism. Baba vangu nemidzimu yavo [My father occasionally gets possessed by his ancestral spirits]and he gives
ancestral advice to the family; so my mother thinks it is my father’s spirits that brought albinism on me so she doesn’t really like me, but I think my father’s ancestral spirits are harmless.”

The zone of childbearing represents a terrain of oppression which attacks the most fundamental of the human rights of women with disability, and in this study such oppression is prevalent in both families and healthcare centres. In a scenario which resembles self-stigmatisation, Danai believes that her mother did not share information on childbearing with her because she has albinism. Society creates stigma and once a person does not refute such creation, she may begin to develop negative thoughts, feelings, low self-esteem and low self-worth. Perhaps Danai’s mother found it difficult to discuss issues of sexuality, which includes childbearing, with Danai, because in African culture the subject is embedded with taboos and secrecy, thereby reducing access to information particularly by minority groups such as women with disability.

Childbearing aspirations of women with disability

The findings of this study show that participants who had not had any childbearing experiences at the time of the study, aspire to have their own biological children. For example, Vimbai who is 22 years old has intellectual impairment, and she lives in a mental healthcare institution in an urban area. She has never married, has no children and she is formally unemployed. She recounted that she wishes to have a boyfriend and to have children with him.

“At first I didn’t like boys, I just liked a boy for a little bit maybe just one day or two weeks and I finish. But now I am thinking that I must find a boy, because I want to marry and to have my own children. I am tired of living here so I want to start my own family in the village.”

However, Tatenda lives at the same mental healthcare institution with Vimbai. Tatenda has intellectual impairment, she is 57 years old and divorced, she has no children and she is formally unemployed. She said:

“The condition here is every woman must have her tubes tied. So all these women you see here with Down syndrome, Schizophrenia or what, their tubes are tied. I was forced to get my own tubes tied when I came here but now I am not worried because I am menopause. People here are also not allowed to love one another, those who do are punished by being denied food. I think the whole thing is just unfair.”

The sexuality of people with disability is usually regarded as socially problematic, a practice which in itself is a symbol of oppression. In addition, persons with disability often confront coercion, limitation, and punishments in scenarios which resemble a serious violation of their human rights. From a human rights perspective, Article 23 (c) of the UN CRPD, clearly states that disabled people should be allowed to retain their fertility in the same manner that every other person does. In addition, Article 23 (b) of the same Convention states that disabled people have a right to responsibly and freely decide on the number and spacing of their own children. The example of Vimbai’s narrative and Tatenda’s narrative as quoted above, resonate with the proclamation that the recognition of rights and the realisation of such rights are two different things that may not be simultaneously achieved. One wonders about the ethical practice of healthcare staff who conduct medical procedures on women with disability without engaging them in dialogue or seeking their approval. Some scholars have noted the ethnocentric characteristics of the medical profession which is embedded with “we are specialists, we know it all” approaches that rarely solicit the viewpoints of clients.

Conclusion

The findings of this study reveal that in spite of the healthcare role that is endowed on staff who work in healthcare centres, such staff are still not prepared to engage with the childbearing experiences of women with disability. It would therefore be most prudent for the recruitment policy of the health sector to consider the inclusion of women with disability at various levels. Such a policy has the potential to create an opportunity for such trained women to bring positive change to the health sector, thereby enhancing sensitivity to the childbearing needs of women with disability. Guided by disabled professionals who may be appropriate role models, the policy may assist women with disability to address the issue of self-stigma which could be affecting a number of women.

The inclusion of the subject of disability and sexuality in the curriculum of all healthcare
professionals would go a long way in promoting the realisation of the sexual and reproductive health rights of women with disability. Such training is likely to bring consciousness to the unique needs of women with disability within the healthcare delivery system, and perhaps raise awareness on the negative impact of taking an ethnocentric approach which does not solicit the viewpoints of clients. The recommendation of disability training concurs with that which is articulated in the World Report on Disability which states that the improvement of knowledge, skills and attitudes of healthcare staff can be achieved by including disability information in their curricula.

Training should buttress the importance of the application of professional and ethical behaviours to all women regardless of ability, and such training should be included in curricula and assessed in examinations. There is also need for a rigorous evaluation of impact which enables the voice of women, including disabled women, to feed back into the policy-making systems to allow for necessary and relevant changes to be made. Nevertheless, while the inclusion of disability in curricula may not automatically translate into action on the ground, the practical involvement of advocacy groups is required to assert the right to a sexual life for people with disabilities. The reality is that facilitating a human rights culture is a multidimensional responsibility that cannot be transformed through curriculum changes alone.

To address the challenge of some traditional beliefs around childbearing, civil society, disabled people’s organisations and other advocacy groups could seek to partner with The White Ribbon Alliance Zimbabwe, which is promoting the concept of Respectful Maternity Care, with the aim of mainstreaming disability in its activities. Such an approach could provide reference points and places of convergence for women with disability, from which they can draw information and seek advice or engage in peer counselling, as well as bringing awareness to the organisation of the significance of taking an inclusive approach. Activities of the Alliance are in part framed around voluntary alliances which include individuals, NGOs, government departments, youths, community members, academic and health training institutions and donors.

In much the same way that the assumption of asexuality made it difficult for women living with HIV to access contraception, prior to PMTCT and anti-retroviral therapies, the same assumption creates barriers for women with disability to access appropriate childbearing information and services. Advocacy could also draw from the example of people living with HIV who became activists, teaching society the importance of treatment literacy and knowledge empowerment through social media, support groups and empowerment.

There is need for the Ministry of Health and Child Care to establish a policy which directs all healthcare institutions to ensure the availability of healthcare facilities that enable disabled women to be appropriately and adequately attended to and to offer communication in appropriate formats such as sign language for the deaf, or other modes that are suitable for people with different kinds of impairment. However, as previously mentioned, it may not be practical to expect all healthcare staff to learn to use sign language; hence it may be useful to design a policy which allows close family or community members to be allowed to act as birth companions in delivery wards.

It is not possible to generalise the findings that have been discussed in this paper; further research on childbearing experiences and aspirations of women with disability and the promotion and realisation of sexual and reproductive health rights in the Global South and particularly within African contexts is required.

**Funding**

This study was funded by Canon Collins Educational and Legal Assistance Trust; The Margaret McNamara Memorial Fund (World Bank) and The Council for the Development of Social Science Research in Africa (CODESRIA).

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Résumé
Le but de cet article est d’élucider les expériences et les aspirations relatives à la procréation des femmes handicapées au Zimbabwe. L’article s’inspire d’une étude qualitative narrative menée par des chercheurs à l’Université du Cap, Afrique du Sud, qui a exploré les expériences de la sexualité des femmes handicapées au Zimbabwe et a utilisé la méthode d’interprétation des entretiens biographiques-narratifs pour créer des données. L’étude a en partie révélé que les femmes handicapées rencontrent souvent divers obstacles qui sont associés au handicap et qui les empêchent de réaliser pleinement leur santé et leurs droits sexuels et génésiques. Certaines participantes ont raconté qu’elles étaient heureuses d’avoir leurs propres enfants biologiques, même si elles se sont déclarées frustrées de souffrir dans la plupart des cas de discrimination à l’intérieur et à l’extérieur des centres de soins de santé génésique. Les participantes qui n’avaient pas eu d’expérience de la procréation au moment de l’étude ont affirmé qu’elles aspiraient à avoir leurs propres enfants biologiques. De toutes les manières, les récits des femmes remettent en question le mythe selon lequel les femmes handicapées n’ont pas besoin d’une place dans le secteur de la procréation en raison de leur handicap.

Resumen
El objetivo de este artículo es aclarar las experiencias y aspiraciones de procrear de mujeres con discapacidad en Zimbabue. El artículo se basa en un estudio narrative cualitativo realizado por investigadores de la Universidad de Ciudad del Cabo, en Sudáfrica, que exploró las experiencias de sexualidad de mujeres con discapacidad en Zimbabue y que utilizó el Método Interpretativo Narrativo Biográfico para generar datos. En parte, el estudio reveló que las mujeres con discapacidad a menudo enfrentan una gran variedad de retos que están asociados con discapacidad y que les impiden juzgar al máximo su salud y sus derechos sexuales y reproductivos. Algunas participantes relataron que están contentas con el hecho de que tienen sus propios hijos biológicos, aunque indicaron sentir frustración con el hecho de que en la mayoría de los casos son discriminadas dentro y fuera de los centros de salud reproductiva. Las participantes que no habían tenido experiencias de procrear cuando se inició el estudio informaron que aspiraban a tener sus propios hijos biológicos. De cualquier modo, las narrativas de las mujeres están cuestionando el mito de que las mujeres con discapacidad no requieren espacio en el ámbito de procreación porque están discapacitadas.