“We do not dare to love”: women with disabilities’ sexual and reproductive health and rights in rural Cambodia

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Abstract: There is an urgent need for an evidence base to inform the implementation of disability inclusive sexual and reproductive health (SRH) policy and programming to address women with disabilities’ largely unattained SRH rights. This paper presents findings from a qualitative study on the sexual and reproductive health and rights (SRHR) of women with disabilities in rural Cambodia. The findings highlight three critical steps to enhance the physical, communicative and financial accessibility of SRHR information and services. Firstly, strengthen women with disabilities’ economic livelihoods, social and financial resources, and thereby, their capacity to make and act on their own SRHR decisions. Secondly, engage women with disabilities as community role models and advocates who actively provide input into health service decision-making, planning and delivery. Thirdly, ensure health centre staff have access to communication resources and aids to strengthen their skills to communicate with women with hearing impairments. Together these steps will support women with disabilities to claim their sexual and reproductive rights and transform the social attitudes of persons in the lives of women with disabilities, including health care staff. DOI: 10.1080/09688080.2017.1332447

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Introduction

Development discourse widely recognises the marginalisation and disadvantage experienced by persons with disabilities.1 Women with disabilities face particular barriers to their economic, social and political participation and are more likely to live in poverty than their non-disabled counterparts or men with disabilities. Feminist analysis has identified that women with disabilities experience unique disadvantages that are the result of intersectional discrimination associated with gender, impairment type and severity, poverty and rurality.1–4 Together these intersections diminish women with disabilities’ social power and access to material and non-material resources.1 This research examined how these intersectional disadvantages shape women with disabilities’ sexual and reproductive health (SRH) experiences and asked whether women with disabilities face additional barriers than women without disabilities.

Worldwide, the sexual and reproductive health and rights (SRHR) of persons with disabilities have been widely and deeply neglected in a historical pattern that includes denied SRHR information, denied rights to establish relationships and to decide whether, when and with whom to form a family.5 Despite specific Articles in the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the SRHR of many women with disabilities continue to be unattainable and little research has examined the specific barriers these women face in low- and middle-income countries. There is an urgent need for an evidence base to inform the implementation of policy and programmes that meet the SRHR needs of persons with disabilities.3

Recent studies demonstrate that persons with disabilities face multiple barriers to access health services6 and that women with disabilities have greater unmet health and SRHR needs than...
women without disabilities. Women with disabilities, however, are excluded from activities that promote access to SRHR information, screening, prevention and care services because disability is incorrectly associated with asexuality, and an inability, and/or lack of desire to bear and parent children. SRHR information and services may be physically inaccessible, communication modalities may be inappropriate, health care systems may lack disability awareness and be poorly prepared to cater for women with disabilities' needs. In the absence of even very basic information on SRHR, women with disabilities do not understand how their bodies work, nor their rights to define what they do and do not want.

In Cambodia, women’s age, education and socio-economic status are key determinants of SRHR practices and access to services, including contraception. The most vulnerable have the poorest access to health and SRH services. Although disability is not identified in policy and research literature on SRHR in Cambodia, it is widely recognised that women with disabilities are one of the poorest social groups. Many families with a member with disability have limited education and struggle to access government services. Cambodian women in general face labour market discrimination and earn approximately 30% less than men; men’s literacy is 40% higher than women’s and boys’ school enrolment is 50% higher than girls’ by age 15. Gender stereotypes together with social misconceptions that associate disability with inability reinforce women and girls with disabilities’ poor social status. These culturally based stigmas expose women with disabilities to greater rates of physical, verbal and sexual abuse than women without disabilities and they struggle to gain the practical and financial support they need to access health and SRHR information and services.

This article presents findings from a larger qualitative study conducted on the SRHR needs of both men and women with disabilities in rural Cambodia, on women with disabilities’ SRHR needs. It contributes to the current paucity of knowledge on the particular barriers women with disabilities experience when they seek to claim their SRHR in low- and middle-income countries.

**Theoretical framework**
The rights-based approach and social models of disability as espoused by the CRPD provide the theoretical framework for this project. The CRPD notes that “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society with others on an equal basis with others.” Such an approach conceptualises disability as a consequence of socio-economic structures and physical barriers that accommodate disability or not, and not merely as a matter of bodily function. Research practice must therefore start with the recognition of disability as an issue of rights and discrimination.

Critical geographical approaches to disability also frame this project’s theoretical, methodological and analytical approach. Critical geographies spatialise social and rights-based approaches to disability and draw attention to the particular spatial barriers that entrench and distinguish persons with disabilities’ oppression from that of other social groups. Physical space(s) assume full mobility, hearing and visual capacity and thereby fail to cater to the needs of persons with disabilities. By doing so space(s) exclude persons with disabilities. Consequently, mobility and sensory disadvantages are embedded in place because space(s) assume able-bodied, sensory and intellectual capacities.

Critical human geographies highlight the dynamic, ambiguous and contested nature of physical and social space(s) whereby power relations are played out in and through space. Political possibility, oppression and contestation are thus embedded in place. The conceptualisation of built environments and women with disabilities themselves as negotiable, dynamic and changeable helps to dislodge entrenched and disabling power relations that play out in the everyday relationships that surround them. This “relational” view of space and place is an appropriate starting point for understanding the SRHR of women with disabilities. Furthermore, studies on women with disabilities’ SRHR have been based upon professional opinions and have rarely explored the lived experiences of women. This study recognised women with disabilities as experts of their own experiences and contributes to filling this conceptual gap. It is the first study of its kind in Cambodia.

**Methods**
This article draws on qualitative research that aimed to provide foundational understanding of persons with disabilities’ current SRH care and
needs and for this knowledge to inform future project interventions. The German Development Cooperation (GDC) through Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) commissioned this research and employed the first author to conduct this study. The first author has worked in Cambodia for two decades and has conducted multiple research projects in partnership with the Cambodian Disabled People’s Organisation (CDPO) and provincial disabled people’s organisations (DPOs).13,21,22 She is fluent in Khmer and led a six-person research team that conducted field work in Kampot province over eight days in September 2015. The first author’s extensive in-country experience made the short field work period possible.

Kampot province was selected as a field site as it is one of four provinces where GIZ supports the Cambodian Ministry of Health to implement a three-year maternal and child health project. The GIZ project has pre-established relationships with health centre staff, disability focused NGOs and local DPOs. The research team was made up of three representatives from CDPO (two female and one male), and representatives (two female and one male) from three district level DPOs. Together the team constituted two pairs of female interviewers and one pair of male interviewers who interviewed women and men with disabilities, respectively. Findings for women with disabilities are reported on here.

The provincial DPOs recruited women with disabilities through their networks. Women had to be within the reproductive age range (15–49 years) and self-identified as having a disability. All interviewees except one were in the reproductive age range. Recruitment aimed to maximise diversity of participants. Women with hearing impairments were recruited through a disability focused NGO. All women with hearing impairments participated in a focus group discussion (FGD) conducted by a female sign language interpreter, a female English-Khmer interpreter and led by the first author. Women who had engaged with the NGO were both more fluent in sign language and had greater knowledge of SRHR than village-based women with hearing impairments. Another FGD was conducted with women with physical and sensory impairments. A total of 33 women with disabilities participated in this study: 25 women participated in in-depth interviews and 8 women participated in FGDs. The average age of female participants was 35 years. Almost half had mobility impairments (42.5%), just under a third had visual impairments (27%), 15% had hearing impairments and the remaining women had a combination of physical and developmental impairments (Tables 1 and 2).

The CDPO staff and the first author led the in-depth interviews using an interview checklist that included questions on how and where women learn about SRHR, their experience of marriage and/or aspirations for marriage, childbirth, birth spacing, access to and decision-making about contraception, abortion and health-seeking behaviour. Interviews were conducted in Khmer, tape recorded and transcribed into written English with participant consent. Interviews lasted between 30 and 60 minutes depending on the SRHR experiences of interviewees. All transcripts were read three times by the first author, coded and sorted thematically in a grounded theoretical and analytical approach.23 The Cambodian Ministry of Health Research Ethics Committee approved this research in June 2015. The Ministry of Health are GIZ’s counterpart and GIZ’s programme sits within the Ministry. All GIZ programme activities, including research, must be approved by the Ministry of Health and for this reason Ministry of Health ethics approval was sought.

Women with intellectual impairments were not included in the selection criteria as DPO partners have limited understanding and skills to conduct such research. The SRHR of women with intellectual impairments warrants a stand-alone research project, or at least specific training and methods and this was not possible within this research project. Only one person read the interview transcripts and conducted the data analysis which may have led to different interpretations being missed. GIZ programme staff supported data analysis and preliminary findings were presented to GIZ maternal and child health programme staff and to the research team for critical discussion.

Intersectional barriers to marriage

Of the 33 women with disabilities who participated in this study, 16 were married. Two-thirds (10 of 15) had a disability at the time of marriage. Women with disabilities in the reproductive age range had an average of 1.26 children per woman. Furthermore, 19 of 33 women interviewed did not have children.
Table 1. Demographics of female interviewees.

| ID  | Age | Disability Type | Marital Status | No. of children | Education | Living with | Work                                      |
|-----|-----|-----------------|----------------|-----------------|-----------|-------------|-------------------------------------------|
| F01 | 42  | Mobility        | Married        | 4               | Grade 1   | Spouse and children | Farmer                                   |
| F02 | 25  | Mobility        | Married        | 1\(^a\) (pregnant) | Grade 9   | Spouse and children | Raises pigs                               |
| F03 | 52  | Mobility        | Married        | 5               | Grade 3   | Spouse and children | Farmer; raising animals                   |
| F04 | 23  | Mobility        | Single         | 0               | Grade 12  | Parents\(^b\)       | At home; domestic work                   |
| F05 | 43  | Visual\(^\wedge\) | Married        | 5               | Grade 2   | Spouse and children | Farmer                                   |
| F06 | 45  | Mobility        | Married        | 2               | Grade 8   | Spouse and children |                                          |
| F07 | 24  | Visual          | Single         | 1               | Grade 6   | Parents       | Look after child at home                  |
| F08 | 44  | Blind           | Married        | 2               | Grade 7 (Diploma) | Spouse and children | Farmer/ construction                      |
| F09 | 49  | Mobility        | Married        | 0               | Grade 7 (Diploma) | Spouse | NGO staff, market seller                  |
| F10 | 48  | Visual          | Single         | 0               | Grade 6   | Parents       | No paid work                             |
| F11 | 48  | Mobility        | Married        | 0               | Grade 7   | Spouse | NGO staff                                |
| F12 | 58  | Visual          | Married        | 0               | None      | Spouse | Small business                           |
| F13 | 28  | Blind           | Single         | 0               | None      | NA   | Domestic work                            |
| F14 | 53  | Visual          | Married        | 5\(^c\) | Grade 4   | Spouse and children | Sells second hand clothes                |
| F15 | 41  | HIV             | Married        | 4               | Grade 4   | Spouse and children | Farmer and small business               |
| F16 | 27  | Mobility        | Married        | 2               | Grade 1   | Spouse and children | Farmer                                   |
| F17 | 30  | Mobility        | Married        | 1               | Grade 12  | Spouse and children | Small shop at home                      |
| F18 | 36  | Physical        | Single         | 0               | NA        | Parents | Animal raising, farming                  |
| F19 | 25  | Mobility        | Married        | 1               | Grade 7   | Spouse and children | Farming, domestic work                  |
| F20 | 18  | Developmental   | Single         | 0               | None      | Parents | Domestic work                            |
| F21 | 21  | Mobility        | Single         | 0               | Grade 12  | Parents | Study                                   |
| F22 | 35  | Mobility        | Single         | 0               | None      | Widowed father (also a man with disability) | Home; farming; raising animals |
| F23 | 45  | Mobility        | Single         | 0               | None      | NA | Tailor                                   |
| F24 | 34  | Mobility        | Married        | 3               | None      | Spouse and children | Raise chicken; home                     |
| F25 | 30  | Blind           | Single         | 0               | None      | Parents |                                          |

\(^a\)Parents includes siblings.
\(^b\)Of those with visual impairments, 5 were blind in one eye.
\(^c\)3 of her 5 children have an intellectual impairment.
\(^d\)Total of 36 children.

NA: Not Available.
Women with disabilities did not feel attractive and confident because of gender and disability specific social norms

Marriage for women with and without disabilities in Cambodia is only possible when both families agree to the union. Women have to wait for a potential husband to fall in love with them and/or for the family of the potential spouse to ask for marriage. All Cambodian women are unable to approach the family of a potential husband and are thus unable to choose their spouse. Women with disabilities faced the intersectional barriers of gender and disability and experienced heightened limitations on their social and decision-making power when they wanted to enter an intimate relationship. As one informant explained:

“Even if we love them, we don’t know if they will love us back… we are disabled… so how can we choose them?” (FGD, 35 year old woman with visual impairment)

They explained that, similarly to other women, whether they marry or not depends on a man loving them. However, they felt this was unlikely to occur because men did not see them as attractive or desirable women who are capable of the reproductive and productive work of mothering. Furthermore, women with disabilities did not consider themselves to be beautiful because of these negative gender and disability specific social norms:

“I’m a person with disability… no one sees [is attracted to] me… they think that I can’t do much work… so nobody wants me and my appearance looks bad… they only want to marry pretty girls who are not disabled.” (35 year old interviewee, single woman with mobility impairment)

Women with disabilities were not confident in their ability to be able to earn a livelihood, to care for a husband and to have sufficient financial resources to raise children. Women with hearing impairments were concerned about communication difficulties if they married a hearing husband and preferred husbands with hearing impairments. Their parents, however, wanted them to marry hearing husbands or not marry at all. Some women with disabilities continue to believe that the challenges they face are inherent to their impairment. For example:

“We are not as brave as normal people. We are disabled so we have to do something according to our condition.” (FGD, 49 year old woman with mobility impairment)

These fixed beliefs do not help to build women with disabilities’ confidence in their ability to contribute to their households’ livelihood, let alone to establish their own families and support husbands and children. The reality, however, is that many women with disabilities actively support others as wives, mothers, daughters and sisters.

Women with disabilities who did marry followed the wishes of their parents and accepted

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Table 2. Focus group: women with disabilities.

| ID | Age | Disability type | Marital status | Number of children | Education | Living with | Work       |
|----|-----|----------------|----------------|-------------------|-----------|-------------|------------|
| P1 | 35  | Blind          | Single         | 0                 | G3        | Older brother’s family | Agriculture |
| P3 | 49  | Mobility       | M (divorced)   | 0                 | G4        | NA          | Small business |
| P4 | 37  | Multiple (physical/mobility) | Single | 0                 | G3        | Sister      | Raising pigs |
| P5 | 28  | Deaf           | Separated      | 2                 | NA        | NA          | NA         |
| P6 | 22  | Deaf           | Single         | 0                 | G12       | NA          | NA         |
| P7 | 27  | Deaf           | Single         | 0                 | G6        | NA          | NA         |
| P8 | 31  | Deaf           | Single         | 0                 | G5        | NA          | NA         |
| P9 | 28  | Deaf           | Single         | 0                 | G1        | NA          | NA         |
husbands chosen for them by their parents. Even when men fell in love with them, the families of the potential spouse did not agree to marriage because they believed they were incapable of caring for a husband and children. Women with disabilities noted that their “rights” do not translate into the social freedom to choose a spouse:

“We are women with disabilities, we are discriminated by non-disabled people. Sometimes, both sides – the man and the woman love each other but the parents say [to the man] ‘why do you have to marry her? If your wife is like that [disabled] after you get married, you will have to care for her’. So there is social discrimination…so women with disabilities have great difficulties in finding a partner…unless that man commits to love us, we can marry him…only if the man volunteers himself, then we can accept him.” (FGD, 37 year old woman with physical and mobility impairment)

Adherence to the wishes of parents is not only the cultural norm, (albeit one that is slowly changing), but provides women including those with disabilities with a safety net in case anything should go wrong in the marriage. Although the security of all women is at stake if they marry without parental consent, these risks were heightened for women with disabilities. Women feared that if they married they would be unloved, treated badly or, even worse, be abandoned by their husband. They feared not being able to depend upon family in the future should they find themselves divorced or separated and unable to support themselves. As women with disabilities, the challenges they face in meeting daily needs are heightened as the most readily available forms of livelihood depend upon physical strength, mobility and sensory acuity.

Women with disabilities were perceived as a burden by the families of potential spouses

Women with disabilities reported that potential spouses and their families were afraid that a disabled wife would be a burden and an object to be cared for rather than herself being able to care for her husband and children. The societal norm of women caring for husbands is unsettled by women with disabilities. For this reason, the parents of women with disabilities were described by women as having low expectations of their daughters’ marriageability and, in some cases, they proposed marriages to men that non-disabled women would consider unattractive. For example:

“My parents introduced me to a man who had children already and wanted me to marry him but I didn’t want to.” (FGD, 31 year old woman with hearing impairment)

Women with visual, hearing and developmental impairments considered themselves to be even less likely to marry than women with physical impairments. A woman with Down’s syndrome, for example, explained that her parents do not consider marriage an option for her because they are afraid a husband would not care for her properly. Interviewees did, however, exercise some agency by rejecting potential husbands that parents selected for them and reported that their parents did not force them to marry. Women with disabilities also reported that parents would not stop them from marrying but made it clear that they thought marriage was problematic. For example:

“They [my family] give me advice…they do not prohibit me [from marrying] but they were afraid that I will have problems in the future…If my husband abandoned me, my parents will not take care of me in the same [way] as they would if I am single [and never marry]…I will have a lot of difficulties to earn [money] and support my children alone…if he [my husband] runs away [leaves] from me…I will be neglected by my family.” (35 year old interviewee, woman with mobility impairment)

Although data were not analysed by whether women had a disability at the time of marriage, none of our interviewees who had a disability at the time of marriage or who had acquired a disability after marriage had been abandoned by their husband. Women with disabilities prior to marriage, however, feared that potential future husbands may leave them. Only one woman had separated after seven years of marriage. This woman was educated — a high school graduate — and was not financially dependent upon her husband as she had her own source of income from a small home-based shop. Several women with disabilities were happily married and pleased that their husbands took good care of them, in one case even more so than before she acquired her disability:

“My husband thinks that I am disabled and I can’t work as well as before…Now he is more open minded
with me… what I want to do, I do… he feels ok. That's much easier than before I was disabled… before I acquired disability in fact it was more difficult and after disability it is easier." (45 year old interviewee, woman with mobility impairment)

Other women reported that their husbands did not allow them to do heavy domestic work such as carting water and chopping firewood, and only allowed them to do light work, such as the washing:

"I said that if he [my husband] would ask his parents, I would agree with him [to get married]. And he asked his parents and I agreed with him… but I told him I am a disabled person, you shouldn't marry someone like me. I even fall down when I try to walk but he told me that he would do everything for me. I have never carried water once, he does everything for me. I only wash the clothes." (34 year old interviewee, woman with mobility impairment)

These stories demonstrate that men are able to respond to and support women’s impairment-related needs within marriage. There are thus exceptions to the dominant social narrative of stigma and discrimination and these need to be shared widely to change stereotypes. Images of women with disabilities as capable women, wives, mothers and care givers need to be promoted.

When women remain single and childless intersectional disadvantages are heightened

Just over half (17 of 33 women) of female informants were single and without children. Women with disabilities who had never married, did not have children and social support experienced the greatest vulnerability and were most at risk of violence, poverty and social discrimination. The experience of a 58-year-old woman with a mobility and visual impairment illustrates how marriage status, poverty, gender and disability intersect and form complex disadvantages. She had neither parents nor older siblings to arrange marriage for her when she was younger and faced barriers to marriage related to her disability, poverty and lack of natal family support. She explains her decision to marry in her late forties:

"I married at an old age. If I married when I was young, I may have had children… but because I am looked down on, that's why I got married at an old age… just for support… while I stay alone, I was looked on and didn't have a house… the neighbours used to speak ill about me… as I am weak and stay alone at night… they often violated me… stole my ear rings… but I didn't know where to go as I am poor and struggle to live alone… and the one who stole my chickens at night, they came to hit me…." (58 year-old interviewee, woman with mobility and visual impairment)

Living alone as a poor, single woman with disability made her an easy target for abuse by fellow villagers:

"While I was alone [before marriage], they wanted to curse me… accuse me… they [villagers] call me ‘blind’ and I don't dare to come out [from the house]… I knew who they were [those who came to verbally abuse me], but I dare not say [anything] to them… because I am alone and afraid they will [further] abuse me… I am disabled and alone.” (58 year old interviewee, woman with mobility and visual impairment)

One of the few strategies available to her was to become a second wife in a polygamous marriage. As a married woman she felt more secure and villagers stopped looking down at her:

"[I] have no feeling of loneliness… I feel stable with him [my husband], I am not afraid… if there is a male in the house, thieves do not dare to do such things.” (58 year-old interviewee, woman with mobility and visual impairment)

Her husband is known to have other women in addition to his first wife and currently requires full-time care following a stroke two years ago. Even though she is now married and her husband’s primary carer, she continues to worry about having no house or land to live on when he dies. As second wife she has no claim to his land, as first wives do. Without land and in the absence of other sources of social support, she will have no place to live, no safety net and very few resources available to use to meet her daily needs. In rural contexts where the main forms of livelihood depend upon mobility, vision and physical strength, women with mobility and sensory impairments have specific impairment-related barriers and are thus more disadvantaged than those without disabilities.

**"Qua" is a derogatory term for blind.**
Women with disabilities are easy targets for abuse

Five women in this study reported verbal, physical or sexual abuse, and unwanted sexual harassment including being touched inappropriately and kissed.† Women with disabilities felt that they were easy targets for abuse:

“The man thought I would not be able to tell my father… he told me not to tell anyone… I told another man not to kiss me too… because I am very shy… I am scared when I am at home alone… men know that I have a disability and my parents know that he [this particular man] wants to rape me… the man [also] harassed me when I was 16 or 17… he touched my breasts and someone saw this and told my father.” (18 year interviewee, woman with Down’s syndrome)

Rape is common for young women in Cambodia. 24 Women with hearing, visual and intellectual impairments felt that they are particularly vulnerable as perpetrators think they are unable to retaliate, scream or tell others. Women with disabilities felt unsafe and afraid of sexual violence and rape. They may be without the social support and financial resources required to get help if needed:

“I’m scared because I don’t know who has good intentions and who has bad… because I stay alone and I can’t see… I’ve heard that women with disabilities get raped… harmed… so I get scared and worried that such things happen to me… I don’t know how I could ring someone because my phone has no credit… so I may have to yell to the neighbours.” (35 year old interviewee, woman with visual impairment)

Interviewees reported that non-disabled husbands and family members get frustrated with them for the difficulties disability puts upon them. For example, a woman with a hearing impairment described how her father hits her because of his frustration at not being able to communicate easily with her. A woman with a visual impairment described how she is able to fulfil her sexual role as a wife, but her inability to work frustrates her husband and results in verbal abuse:

“For sexual side of things… [it is] no problem… but I can’t work and he got mad at me… when he curses me, I have no feeling to sleep with him… He [my husband] curses me… he feels ashamed… he curse me ‘you will always be blind’… This made me get so mad at him.” (42 year old interviewee, woman with visual impairment)

In two other cases women with disabilities responded to inappropriate abusive and threatening behaviour proactively and contacted local authorities – the village head, police and Commune Council for protection. These women had both learnt how to respond to inappropriate behaviour and about their rights as women at school and through NGO programmes.

Women’s access to SRHR information and services is low

Women with disabilities’ SRHR knowledge was low and mirrored patterns in the general population. Informal conversations among family members, peers and neighbours are the first key source of information for men and women as other research in Cambodia confirms. 9, 10, 25 Findings from this study found that women with disabilities learnt about SRHR from three main sources: social networks of family, friends and neighbours; village-based information sharing meetings organised by Village Health Support Volunteers (VHSV) and/or NGOs, or directly from health centre staff and/or doctors. Young women, for example, learnt about menstruation by listening to the conversations of older women:

“I heard my mother and other women talking about periods and I learnt this way.” (48 year old interviewee, woman with mobility impairment)

Marital status is a key determinant of women with disabilities’ SRHR knowledge, especially of contraception. Married women learnt about contraception and SRH care by talking with family members, peers and neighbours. Not all married women were equally able to access information, as married couples without children and those with older children were not systematically invited by VHSV and/or the village head to attend information sharing meetings with VHSV and/or NGOs. These findings suggest that only married couples with young children are systematically invited to attend these meetings. Contraception is not generally used until after the birth of the first child and it is likely that health staff consistently recognise the

†Women were not directly asked about their experience of physical, verbal and sexual abuse and the incidence could have been greater than our data suggests.
need for family planning once the first child is born. Women who were not invited to meetings learnt informally by listening in:

“They were just talking with each other [about the withdrawal method]… the old people… and I just listened to them from afar.” (44 year old interviewee, married woman with visual impairment)

Single women with disabilities had very limited knowledge, particularly those under 30 years of age. They were shy when speaking about SRHR and assumed that this information was not relevant to them:

“My body looks like this [disabled]… so that is why I do not want to know [about SRHR].” (36 year old interviewee, single woman with physical impairment)

“I am the one who doesn’t have a husband like other people, so I don’t pay much attention.” (23 year old interviewee, single woman with mobility impairment)

Married informants also gained SRHR information by visiting the Commune Health Centre and private practitioners. Women with hearing impairments faced specific barriers to gaining information in each of these verbal formats. They reported particular difficulties communicating with health centre staff and relied upon family members to assist them at the health centre. They experienced health consultations as confusing and frustrating. Women left the consultation knowing very little about the condition they sought care for and were reluctant to visit the health centre in future. For example:

“It is difficult because the health centre staff can’t use sign language and we need a translator… when we go to the doctor we don’t really know what is going on.” (FGD, 31 year old single woman with hearing impairment)

When women were encouraged to ask questions and to seek out SRHR information from health care professionals, VHSV and others they were keen learners.

Discussion

It is not surprising that women with disabilities have little knowledge of SRHR given the low levels of education among them, the overall poor quality of education in Cambodia and the disability specific barriers they face to learning about SRHR. Single unmarried women with disabilities face particular age, gender and disability-related barriers to SRHR information and were concerned about their future marriageability and vulnerability within marriage. Systematic inclusion of SRHR in the school curriculum is important and urgently required. Currently information about sexual development is taught at higher grades but given the low school completion rate in Cambodia, particularly among persons with disability, sexual education through channels other than school should be encouraged. Low health literacy among the general population, and particularly for women with disabilities, means that SRH information needs to focus on simple and readily understandable key messages delivered in multiple formats.

Women with disabilities in this study identified the need for greater access to information at the village level, particularly in face-to-face formats, as well as communication aides for women with hearing impairments, such as visual communication boards at health centres. Such information must be made available to single persons and to married couples, with and without children, with and without disabilities, in urban, rural and remote areas. SRHR programmes also need to be cognizant of the different needs of married and single women with disabilities. Training and awareness raising of health care professionals, parents and teachers in how to relate to, and communicate about these issues with young people is required to ensure that young people feel welcome and safe when seeking such information.10

Awareness raising campaigns should replace gendered, social stereotypes with positive and empowering stories of women with disabilities as valued, full members of society worthy of respect and as rights holders as women, irrespective of their status as wives and mothers. Access to SRHR information and services is mediated through non-disabled others – spouses, parents, other family members, neighbours and health care staff. SRHR programmes need to target these stakeholders and work together with women with disabilities and their representative organisations to raise societal awareness of persons with disabilities as sexually capable beings just like everyone else. Local authorities play an important role in social planning and DPOs need to engage and expose them to disability and strengthen their inclusive skills. DPOs can identify role models among their members, such as women with disabilities who have given birth already, who demonstrate their
ability as women, partners and parents and by doing so, play an active role in driving changes in underlying harmful gender norms.

Conclusion

Women with disabilities experience intersecting barriers associated with gender, impairment type, poverty, rurality and social support to the realisation of their SRHR. In rural contexts where the main forms of livelihood depend upon mobility, vision and physical strength, women with mobility and sensory impairments experience specific impairment-related barriers and are thus more economically disadvantaged than those without disabilities. In addition to the gendered cultural norms around marriage, women with disabilities encountered disability-specific stigma and social norms that fail to recognise them as capable women worthy of respect, love and meaningful lives. By marrying, women with disabilities fulfil a socio-cultural norm that brings them status as wives and mothers alongside their non-disabled peers. However, whilst a spouse can be a source of support, love and care, they can also be abusive and unsupportive. As married and single women, women with disabilities have heightened vulnerability to abuse, can have greater health and SRH needs than women without disabilities and yet have poorer access to information and services. There is an urgent need to ensure that current SRHR policy and programmes include the specific needs of women with disabilities.

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Résumé
Il est urgent de disposer d’une base de connaissances pour guider la mise en œuvre de politiques et programmes de santé sexuelle et génésique inclusifs en matière de handicap, pour faire valoir les droits largement non réalisés des femmes handicapées dans ce domaine. Cet article présente les conclusions d’une étude qualitative sur la santé et les droits sexuels et génésiques des femmes handicapées au Cambodge rural. Les résultats dégagent trois mesures essentielles pour améliorer l’accessibilité financière, communicative et physique à l’information et aux services de santé et de droits sexuels et génésiques. Premièrement, il faut renforcer les moyens économiques et les ressources financières et sociales des femmes handicapées, et élargir ainsi leur capacité à prendre et appliquer leurs propres décisions en matière de santé et de droits sexuels et génésiques. Deuxièmement, il est souhaitable de recruter les femmes handicapées comme modèles de rôle dans la communauté et comme militantes qui contribuent activement à la prise de décision, la planification et la prestation des services de santé. Troisièmement, il convient de garantir que les effectifs des centres de santé aient accès à des ressources et auxiliaires de communication pour relever leurs capacités à communiquer avec...
des femmes malentendantes. Ensemble, ces mesures aideront les femmes handicapées à revendiquer leurs droits sexuels et génésiques et transformeront les attitudes sociales des personnes dans la vie des femmes handicapées, y compris le personnel de santé.

mujeres con discapacidad auditiva. Juntos estos pasos apoyarán a las mujeres con discapacidad para que reivindiquen sus derechos sexuales y reproductivos, y transformarán las actitudes sociales de las personas en la vida de las mujeres con discapacidad, incluido el personal de salud.