CHAPTER 4

A CRITICAL ANALYSIS OF ACCESS TO MATERNAL, SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR WOMEN WITH DISABILITIES IN UGANDA

*Florence Ndagire**

Summary

Global statistics indicate that 15 per cent of the world's population experience some form of physical, sensory, developmental, intellectual or psychosocial disability. Over 12 per cent of Uganda's population lives with some form of disability. Disability is an evolving concept that requires adequate attention if barriers, including access to maternal, sexual and reproductive health (MSRH) services, are to be overcome. The interface of MSRH rights and disability rights highlights the intersectionality of discrimination in terms of gender; SRH – as a discourse under the second generation of rights; and women with disabilities as a marginalised group. Hence, this paper positions disability rights as the individual right of a woman with disability requiring specific attention, and as a collective right that must be mainstreamed in all legal and policy frameworks. Although experiencing the same maternal healthcare needs as non-disabled women, women with disabilities face different challenges in both the seeking of and the delivery of MSRH services. Reproductive health laws and policies guiding MSRH planning and budgeting, have poorly acknowledged women with disabilities' voices and lived experience. Consequently, barriers continue to manifest themselves, not only in social attitudes but also in women with disabilities' priorities, environmental access to, and appropriately formatted information on MSRH services. This paper provides a critical analysis of existing laws and policies on MSRHR for women with disabilities. It identifies gaps and provides recommendations to promote inclusive MSRHR services for women with disabilities. It presents a qualitative study of literature on existing policies, frameworks, laws and reports, benchmarking them against global commitments and international human rights instruments. It is also enriched by in-depth interviews of key stakeholders in the central region of Uganda.

* PhD (Makerere University); LLM (University of Leeds); LLB (Makerere University); flondagire@gmail.com. My thanks to the anonymous reviewers of this article for their helpful comments. This paper is developed from the author's unpublished PhD thesis. The author is a woman with lived experience of being blind since birth.

F Ndagire 'A critical analysis of access to maternal, sexual and reproductive health services for women with disabilities in Uganda' (2024) 12 *African Disability Rights Yearbook* 66-92
https://doi.org/10.29053/adry.v12i1.5530

1 Introduction

The overlap of maternal, sexual and reproductive health rights (MSRH) and disability rights highlights the intersectionality of discrimination. Discrimination is explored from the perspective of gender and the positionality of women in society, looking at power, poverty, levels of education and employability. It is examined from the perspective of SRH as a discourse under the second generation of rights that highlight health, accessibility, reasonable accommodation and sexual orientation. Discrimination is also examined under the women with disabilities discourse, seen as a marginalised group who experience multiple forms of discrimination and exclusion in society, and for whom the Convention on the Rights of People with Disabilities (CRPD) was developed as late as 2006. Hence, this paper positions disability in terms of both individual and collective rights. As an individual right, it addresses a woman with disability in her pursuit to access maternal and reproductive rights on an equal basis with others, given her unique needs, which requires specific attention. As a collective right access to MSRH must be mainstreamed in all legal and policy frameworks.

The main objective of this paper is to analyse the legal and policy frameworks on access to MSRH services to ascertain whether they appropriately address the MSRH of women with disabilities in Uganda. It examines the level of inclusion and priority given to disability in the policy frameworks and services on access to MSRH and whether the needs of diverse women with disabilities are taken into consideration at the design phase of policies and implementation of programmes. It highlights the positive measures made by the government of Uganda to ensure access to MSRH services by persons with disability. Finally, the paper makes recommendations to ensure inclusive access to MSRH services by women with disability.

The paper is a qualitative study based on a literature review of existing policies, frameworks, laws and reports, benchmarking them against global commitments and international human rights instruments. It was also enriched by in-depth interviews of key stakeholders in the central region of Uganda comprised of the districts of Kampala, Wakiso, Luwero and Mpigi. The central region provides a prototype of women with disabilities within a larger Ugandan population of persons with disabilities.[1] The key informants included women with disability, health workers, representatives from organisations of persons with disabilities, civil society organisations implementing MSRH services, health service providers,

1 Uganda Bureau of Statistics (UBOS) 'National population and housing census 2014 – Main report' (2016) https://www.ubos.org/wp-content/uploads/publications/03_20182014_National_Census_Main_Report.pdf (accessed 20 February 2020).

Government ministries, departments and agencies and development partners. In the interest of confidentiality, pseudonyms are used.

In section 2 of this paper I map global commitments and legal and policy frameworks to provide MSRH services to women with disabilities. Section 3 maps and examines such legal and policy commitments in Uganda. Section 4 presents the fieldwork findings on how such commitments have been implemented. It examines policy-making processes for MSHR service delivery in Uganda, and the lived experiences of such service delivery for women with disabilities – including of discriminatory attitudes, practices and environments. It also highlights health workers positive attempts to adapt implementation of MSHR services for women with disabilities within limited institutional capacity and budgetary support. Sections 5 and 6 offer recommendations to promote more inclusive access to MSRH services.

2 Mapping global commitments, and legal and policy frameworks on access to MSRH services for persons with disabilities

There is significant progress in the recognition and provision of MSRH services in general. However, this is yet to become a reality for women with disabilities at the international, regional and national level in respect of the MSRH rights and services.

2.1 The international framework

The 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), under article 12, recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Further, it prescribes measures for, among others: the reduction of the still birth rate and infant mortality; the provision of health development of the child; the prevention, treatment and control of epidemics, endemics and other diseases; and the creation of conditions which would assure access to all medical services and medical attention in the event of sickness.[2] These measures guide states in strengthening the policy framework on MSRHR. General Comment 22 of the ICSCR Committee recognises disability as a factor of social inequality and obliges state parties to consider disability during the provision of the information on SRH as well as for goods and services.[3] State parties therefore must take specific

2 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, United Nations, Treaty Series, vol 993, p 3, 16 December 1966, art 12.

3 Committee on Economic, Social and Cultural Rights, General Comment 22 (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, UN Doc E/C.12/GC/22 (2016).

measures to provide SRH information in accessible formats – such as braille, sign language, and easy-to-read – failure of which is a violation of SRH rights.

Likewise, article 12 of the 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) requires states to guarantee protection to women by ensuring that they have access to reproductive healthcare, and are protected from coercive pressures.[4] Although CEDAW has been celebrated for recognising the rights of women, it does not include women with disabilities in the articulation of obligations to states to fulfil MSRH services that accommodate their needs. However, General Recommendation 18 recognises the importance of states parties to provide information on disability in their periodic reports.[5] It also recommends for measures to be taken to deal with the situation of women with disabilities in all aspects including SRH rights. General Recommendation 39 recognises the intersectionality of discrimination faced by Indigenous women and girls with disabilities and obliges states to take measures in the form of laws and policies to prohibit discrimination based on gender and disability.[6]

Progressively, the 1989 Convention on the Rights of the Child (CRC) protects the rights of children and adolescents with disabilities and obliges states to ensure that they have effective access to health services.[7] The most outstanding articulation of the rights of women with disabilities in respect of MSRH is the CRPD of 2006. The CRPD is generally acclaimed as the best progressive human rights instrument for advancing the rights of persons with disabilities, and a key global policy document with commitments to promote disability inclusion. Its purpose is to promote the full and equal enjoyment of all the fundamental rights and freedoms by persons with disabilities on an equal basis with others.[8] The CRPD seeks to address the widespread discrimination among women with disabilities in securing many rights, including the right of access to MSRH.[9] It has contributed to the recognition of disability as part of the human rights arena by upholding equality as an essential component of human rights and diversity.[10]

4 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, United Nations, Treaty Series, vol 1249, p 13, 18 December 1979.
5 CEDAW, General Recommendation 18: Disabled Women (Tenth Session 1991), UN Doc A/46/38 (1993) para 6.
6 CEDAW, General Recommendation 39 (2022) on Indigenous women and girls, 31 October 2022, UN Doc CEDAW/C/GC/39 (2022) paras 3, 23(a).)
7 UN General Assembly, Convention on the Rights of the Child, United Nations, Treaty Series, vol 1577, p 3, 20 November 1989, art 2.
8 UN General Assembly, Convention on the Rights of Persons with Disabilities: Resolution adopted by the General Assembly, 24 January 2007, UN Doc A/RES/61/106 (2007) art 1.
9 As above.
10 F Jaramillo Ruiz 'The Committee on the Rights of Persons with Disabilities and its take on sexuality' (2017) 25 *Reproductive Health Matters* 92 https://doi.org/10.1080/09688080.2017.1332449 (accessed 3 December 2024).

Article 2 of the CRPD defines the concept of 'reasonable accommodation' as the necessary modifications and adjustments put in place to meet the needs of persons with disabilities. Addressing these needs is based on the individual and requires consultations to understand the solutions required to meet each individual's needs. Article 23 of the CRPD guarantees to women with disabilities the right to a family, including the right to marry, with full consent, deciding freely on the number and spacing of their children, to have age-appropriate information, family planning and reproductive health education as well as the retention of their fertility. Article 25 also guarantees the enjoyment of the highest attainable standard of health without discrimination on the basis of disability and obliges states to provide the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons in the area of SRH. Further, it requires that health services be as close as possible to people's own communities; ensure same quality of care by the health professionals and to seek the free and informed consent of persons with disability. Article 6 of the CRPD recognises the multiple forms of discrimination faced by women with disabilities[11] and article 12 recognises the right to legal capacity of women with disabilities, which includes the right to contract a marriage, access reproductive health services and supported decision-making.[12] Article 12 obliges service providers to respect and give preference to women with disabilities.

The Global Disability Action Plan of 2014-2021 elaborates on the implementation of the framework of the CRPD with the aim of removing barriers to access to health services, including MSRH services.[13] Importantly, it urges member states to implement the recommendations of the CRPD, working towards the inclusion of persons with disabilities in healthcare with the goal of attaining good health for all persons with disabilities.[14] Subsequently, the 2022 Global Disability Summit came up with 26 commitments that states parties agreed to implement, including ensuring inclusive access to MSRH services. This political commitment is an important milestone that builds the country's national development plan by providing benchmarks and indicators of success to be emulated at the national level.

The 2030 Agenda for Sustainable Development also espouses the healthier lives for all, including access to MSRH services for persons with disabilities.[15] The 2030 Agenda mentions disability in several of its targets 11 times and is inclined to ensure that states meet the goal of disability

11 CRPD, art 6.
12 CRPD, art 12.
13 WHO 'WHO global disability action plan 2014-2021: Better health for all people with disability' (2015) https://iris.who.int/bitstream/handle/10665/199544/9789241509619_eng.pdf?sequence=1 (accessed 20 March 2023).
14 As above.
15 UNDP 'The 2030 Agenda for Sustainable Development' (2015).

inclusion by 2030.[16] Particularly, Goal 3 aims to ensure healthy lives and promote well-being for all at all ages by improving reproductive, maternal and child health. Target 3.7 calls for universal access to SRH services, while target 5.6, on gender equality, further calls for ensuring access to sexual and reproductive health services and reproductive rights.

Article 6 of the CRPD reinforces the non-discriminatory approach of the Convention, in particular in respect of women and girls, and requires that states parties go beyond refraining from taking discriminatory actions to adopting measures aimed at the development, advancement and empowerment of women and girls with disabilities. It promotes measures to empower them by recognising that they are distinct rights' holders, providing channels to have their voice heard and to exercise agency, raise their self-confidence and increase their power and authority to take decisions in all areas affecting their lives.[17] Article 25 of the CRPD provides that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. Further, it enjoins states parties to take all appropriate measures to ensure that persons with disabilities have access to health services, including reproductive health services, that are gender sensitive.[18]

The aim of General Comment 6 is to clarify states party obligations regarding non-discrimination of persons with disabilities as enshrined in article 5 of the CRPD. The broadening of anti-discrimination laws and human-rights frameworks has led to extended protection of the rights of persons with disabilities in many states parties.

In addition to the above covenants, there are many policy agreements in place that provide for the right to health for all. The WHO Constitution of 1946 recognised the rights to sexual and reproductive health and defined the right as a state of complete physical and mental wellbeing of a reproductive health system with the absence of disease or infirmity.[19] The first declaration to call for urgent global action by all governments, and health and development workers to protect and promote the health of all the people of the world, was the 1978 Alma-Ata Declaration.[20] Its Preamble affirmed that health, which is a state of complete physical, mental and social wellbeing, was not merely the absence of disease or infirmity but is a fundamental human right crucial for the attainment of the highest possible level of health. It urged governments to mobilise resources to provide for health of all people. Section VIII calls upon all governments to formulate national policies, strategies and plans of actions to launch national health systems in coordination with other sectors. This implies

16 As above.
17 CRPD, General Comment 3 on article 6: Women and girls with disabilities, 25 November 2016, UN Doc CRPD/C/GC/3 (2016) para 2.
18 CRPD, art 25.
19 WHO Constitution, 1946.
20 WHO, Alma-Ata Declaration, 1978.

that the fulfilment of MSRH services for women with disabilities requires the development of inclusive policies and strategies, and to utilise the available resources to meet the needs of women with disabilities. This Declaration also provides that the people have a right and duty to participate individually and collectively in the implementation of their healthcare.[21]

The UN's flagship Disability and Development Report of 2024 acknowledges that, six years from the end of the implementation of the sustainable development goals, women with disabilities are still left far behind in the provision of sexual and reproductive health rights.[22] Across countries, it states, women with disabilities fall behind non-disabled women in comprehensive knowledge of HIV/AIDS prevention and treatment; have not had their need for modern family planning satisfied; their births are not attended by skilled personnel; they fail to access post-natal care; they do not have the autonomy to make informed decisions regarding their bodies; and are not empowered to exercise their reproductive rights.

Following the 2022 Global Disability Summit in Oslo, the Government of Uganda pledged and committed to review in-service training packages for health workers including management of health conditions, and committed to prioritise disability related support including sign language interpretation.[23] If the Government of Uganda honours her commitment to implement inclusive health services, the support needs of persons with disabilities will be highlighted and addressed.

The Uganda Bureau of Statistics' (UBOS) 2022 statistics show that the infant mortality rate is at 36 per 100 live births (down from 80 in 2000-2001) and the maternal mortality rate in the 7-year period before the survey is 189 deaths per 100 000 live births (down from 336 per 100 000 live births between 2009-2016). These 2022 UBOS statistics show considerable progress in access to MSRH services. Further, they show the fertility rate for women aged 15-49 is 5.2 per 1 000 live births, use of contraceptives is 43 per cent for married and 47 per cent for sexually active women, and teenage pregnancy is 24 per cent.[24] Disappointingly, the key UBOS 2022 findings do not address disaggregated data by disability.[25] This absence limits policy formulation, planning and implementation of maternal health services based on the needs of women with disabilities. For example, the

21 Alma-Ata Declaration, sec IV.
22 UN Department of Social and Economic Affairs 'Disability and development report 2024: Accelerating the realization of the Sustainable Development Goals by, for and with persons with disabilities' (2024) Executive Summary (full report yet to be published).
23 Government of Uganda 'Uganda's commitments to Disability Summit, February 2022' Second Global Disability Summit 2022, Oslo, Norway (2022).
24 Uganda Bureau of Statistics (UBOS) *Report on Uganda household and health demographic survey* (2022).
25 UBOS *Key findings of Uganda demographic and health survey* (2022).

2019 statistics by the UBOS, specifically on disability, indicate that the fertility rate of women with disabilities was 6,3 per cent compared to 5,8 per cent for women without disabilities in the same reproductive age bracket.[26] As the 2019 document was titled 'Bridging the Gap', this level of comparison should have also been mainstreamed into the 2022 statistics to indicate progress in MSRH services for women with disabilities.

The ICPD spotlights the reproductive health needs of women with disabilities as a vulnerable group whose challenges include early/unwanted pregnancies and its negative consequences on the education, economic empowerment and social status of young women and girls with disabilities, as well as sexually transmitted diseases such as HIV/AIDS.[27] Further, to address the MSRH needs and rights of women with disabilities, the ICPD urged states to take the necessary and appropriate measures to establish a range of SRH related programmes and services, including the provision of family planning information, counselling and support during pregnancy and early child care, as well as information on sexuality.[28] On the negative side, it did not consider the accessibility needs of women with disabilities, such as accessible formats of braille, audio and large print for the blind and partially sighted, alternative and augmentative means of communication including plain language, symbols and pictures for women with psychosocial and intellectual disabilities, sign language interpretation for the deaf, tactile for the deaf or blind and captioning.

At the 1995 Beijing Conference, several states, including Uganda, agreed to intensify efforts to ensure the equal enjoyment of all human rights and fundamental freedoms by women with disabilities who face multiple barriers to their empowerment, and to enhance their sexual and reproductive health.[29] The 2019 Nairobi Conference, which reviewed the progress of implementation of the SRHRs, found that while the number of persons infected with HIV/AIDS had decreased and access to family planning services had improved, this was not the case for women with disabilities.[30]

Nevertheless, laws and regulatory frameworks often remain imperfect and reflect an inadequate understanding of the human rights model of disability. Equality and non-discrimination are among the most fundamental principles and rights of international human rights law. Since

26 UBOS *Persons with disability: Bridging the gap through statistics* (2019) https://www.ubos.org/wp-content/uploads/publications/09_2019DISABILITY_MONOGRAPH_-_FINAL.pdf (accessed 3 December 2024).

27 Report of the International Conference on Population and Development (ICPD), Cairo, 5-13 September 1994, para 6.30.

28 ICPD (n 27) sec 1.12.

29 Beijing Declaration and Platform for Action, adopted by the Fourth World Conference on Women: Action for Equality, Development and Peace, 15th September 1995. Women with disabilities, as one of many marginalised groups, are addressed in all sections of the declaration.

30 Nairobi statement on ICPD25: Accelerating the promise.

they are interconnected with the right to human dignity, they are the cornerstone of all rights. The duty to prohibit 'all discrimination' must include all its forms. States parties have an obligation to respect, protect and fulfil the right of all persons with disabilities to non-discrimination and equality. In particular, states parties must modify or abolish existing laws, regulations, customs and practices that constitute such discrimination.[31]

The ICSCR Committee has interpreted the right to maternal health to include the obligation to create measures to reduce still births, improve reproductive health services, family planning, pre and postnatal care, emergency obstetric care, and access to information.[32]

2.2 Regional frameworks

At the regional level, article 16 of the 1986 African Charter on Human and Peoples' Rights (ACHPR), provides for the right to the highest attainable standard. Article 18(4) provides for the right to special measures of protection to persons with disabilities that are appropriate to their physical and moral needs. General Comment 2 of the Protocol to the ACHPR recognises that it is crucial for states to ensure the availability, financial and geographical accessibility, and quality of women's sexual and reproductive health services without discrimination relating to disability or sexual orientation. Enjoyment of rights, therefore, is non-discriminatory, promotes gender equality, and informs women with disabilities of products and health services that are specific to them – including in the area of family planning and safe abortion. The Committee therefore obliges states to provide a comprehensive national health plan with sexual and reproductive health services consistent with the World Health Organisation.[33]

Further, article 14 of the 2003 Maputo Protocol on the Rights of Women in Africa guarantees respect and promotion for the rights to health, including SRH of women. SRH is defined to entail the rights to: control their fertility; to decide on the number and spacing of their children; choice of contraceptive methods; to self-protection and to be protected from sexually transmitted infections including HIV/AIDS; to be informed of one's status/partner's status especially if suspected of having sexually transmitted infections in accordance with agreed international standards and practices; and to receive family planning education, among others. Outstandingly, article 14 obliges states to take effective and appropriate measures to provide adequate, affordable and accessible

31 CRPD, General Comment 6 on equality and non-discrimination, 26 April 2018, UN Doc CRPD/C/GC/6 (2018) paras 2, 4 & 30.
32 CESCR, General Comment 14: The right to the highest attainable standard of health (art 12), 11 August 2000, UN Doc E/C.12/2000/4 (2000) para 14.
33 ACHPR, General Comment 2 on article 14(1)(a), (b), (c) and (f) and article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights, 2014.

health services including information, education and communication programmes to women; establish and strengthen pre-natal, delivery and postnatal health and nutritional services for women during the period of pregnancy and breast-feeding; protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the pregnancy endangers the life of the mother. The obligations and measures stipulated therein have very good intentions geared towards the implementation of quality reproductive health services by states. Significantly, the combined interpretation of article 14 on reproductive rights, with article 23 on the special protection of women with disabilities, provide a robust policy framework for the protection of MSRH rights for women with disabilities.

The African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities' 2018 Protocol is yet another supportive instrument on the rights and reproductive needs of persons with disabilities.[34] This instrument came into force in June this year, yet has still only been ratified by ten states parties. The instrument reiterates the provisions of the UN CRPD under articles 6 on non-discrimination, 23 on the right to family, and 25 on sexual and reproductive health rights. The Protocol enjoins states to take all effective and appropriate measures to ensure that persons with disabilities have access to health services including SRH on an equal basis with others. It brings on board the concept of reasonable accommodation requiring: access to quality reproductive health services based on individual disability needs; accessibility to information and communication; informed consent; supported decision making premised on the fundamental concept of legal capacity of persons with disabilities; and, training of health workers on disability inclusion.[35] It provides a framework and guiding principles for the state party in formulating an inclusive MSRH policy for women with disabilities.

3 The legal and policy framework in Uganda

An analysis of the inclusivity of the Ugandan legal and policy framework in respect to MSRH for women with disabilities is the focus of the proceeding debate. Uganda is a state party to several human rights instruments and is bound by international customary law to implement the obligations stipulated therein, enshrined under article 287 of the Constitution, failure of which is a violation of international human rights law.[36]

34 African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities, 29 January 2018.
35 As above.
36 Constitution of the Republic of Uganda, 1995, as amended, art 287.

Generally, Uganda has relatively progressive laws and policies that provide for MSRH services for all citizens. In 2008, Uganda ratified the CRPD without any reservation.[37] This noble action notwithstanding, there is a huge gap between policy and practice in respect to MSRH services for persons with disabilities.

Having ratified the CRPD, the following analysis assesses the extent to which Uganda has incorporated the rights of persons with disabilities in the MSRH. Objective XIV of the Constitution of 1995 is to the effect that the state shall endeavour to fulfil the fundamental rights of Ugandans to social justice and economic development and shall in particular ensure that all Ugandans have access to health services, including sexual and maternal health services.[38] Objective XX guarantees access to basic medical services to the population which includes women with disabilities.[39] Article 8A of the Constitution provides that Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy.[40] It enjoins parliament to make laws to give effect to article 8A, placing on it the responsibility to enact a law on MSRH rights. Article 32 of the 1995 Constitution provides for affirmative action for marginalised groups, including persons with disabilities, disadvantaged by the past injustices. The terms affirmative action, equality and non-discrimination and respect for the inherent dignity of persons with disabilities, implies a positive obligation by the Ugandan government to prioritise women with disabilities in access to MSRH services and to address their needs through reasonable accommodation. Article 35 of the Constitution guarantees the rights of persons with disabilities to respect for their inherent dignity and pledges to take measures to realise their rights.[41] Article 45 of the Constitution provides for non-derogable rights, including freedom from torture, inhuman or degrading treatment or punishment.[42]

In the 2020 case of *CEHURD v Attorney General*, the Constitutional Court judged maternal health services and obstetric care as a constitutional right. The government's omission to adequately provide basic healthcare services, including sexual and reproductive health, was characterised as a violation of the right to health, and inconsistent and in contravention of articles 8A, 39, 45 and objectives and directive principles of state policy 14

37 Forward, Ministry of Gender, Labour and Social Development *The national comprehensive action plan on the rights of persons with disabilities, 2020-2025* (2020) https://www.apminebanconvention.org/fileadmin/_APMBC-DOCUMENTS/StatePlans-policies/Uganda-Disability-Plan-2020-2025.pdf (accessed 3 December 2024).

38 Constitution of the Republic of Uganda, 1995 (as amended), Objective XIV, directive principles of state policy.

39 Constitution, as amended, Objective XX of the directive principles of state policy.

40 Constitution, as amended, art 8A.

41 Constitution, as amended, art 35.

42 Constitution as amended, art 45.

and 20. Further, it undermines the right to life implicit in article 22 of the Constitution, and the rights of women as defined in article 33.[43]

Nevertheless, the Constitution appears to provide a right with one hand and takes it away with the other. At the intersection of women with disability, lies the LGBTIQ+ community with disabilities who are criminalised and discriminated by Uganda's legal framework. Although a state party to the International Covenant on Civil and Political Rights (ICCPR) and bound by international law to implement non-derogable rights, the Government of Uganda's 2023 Anti-Homosexuality Act remains unique in its vindictiveness.[44] Uganda is one of only 12 countries where, according to section 3 of the Act, private, consensual same-sex sexual activity is punishable by the death penalty. This is a violation of article 5 of the ACHPR which recognises the right for every individual's dignity to be respected and prohibits all forms of exploitation and degrading treatment. It is also a violation of article 5 of the Universal Declaration of Human Rights that provides for the same provisions, and article 3 of ICCPR enjoins states to ensure equal rights of men and women to the enjoyment of all civil and political rights set out in the Covenant. The death penalty set out in the Anti-Homosexuality Act violates international human rights standards since it is tortuous and degrading to those who identify as LGBTIQ+. To later embed this position, the Constitutional Court found that individual identity rights (including autonomy) might be waved in favour of majority cultural values, holding that the Constitution's mandate in Objective XXVI(a) provides for the state to enact laws that 'promote and preserve those cultural values and practises which enhance the dignity and well-being of Ugandans', where individual autonomy can be constrained by societal interests.[45]

Using similar legal relativism, article 22 of the Constitution prohibits and restricts the legalisation of abortion in Uganda by providing that no person shall be allowed to take the life of the unborn child. In order to reinforce this provision, section 141 of the Penal Code Act criminalises abortion and imposes a penalty of 14 years' imprisonment.[46] Thus, although the right to safe abortion for women and girls with disabilities is recognised in article 14 of the Maputo Protocol and ICESCR's General Comment 22,[47] Uganda has put a reservation on article 14, rejecting the obligation to implement safe abortion services.[48] This violates the rights to maternal, sexual and reproductive health and impedes the purpose of the

43 *CEHURD v Attorney General* Constitutional Petition 16 of 2011.
44 Anti-Homosexuality Act, 2023 https://ulii.org/akn/ug/act/2023/6/eng@2023-05-30 (accessed 15 September 2024).
45 *Fox Odoi-Oywelowo and 21 others v Attorney General and 3 others* Consolidated constitutional petitions 14, 15 & 85 against the Anti-Homosexuality Act, Judgment of 2023, 231-234.
46 Penal Code Act, sec 141, cap 120, Laws of Uganda.
47 Maputo Protocol on the Rights of Women in Africa, 2003, art 14.
48 A Kagaha & L Manderson 'Power, policy and abortion care in Uganda' (2021) 36 *Health Policy Plan* 187.

Protocol, contrary to the Vienna Convention on the Law of Treaties.[49] Indeed, Uganda's reservation to legalise safe abortion, enshrined in article 22 of its Constitution, Kagaha & Manderson (2021) argue, remains a considerable contributor to maternal deaths among women and girls, including with disabilities, using unsafe practices.[50]

Although more persuasive than directive, section 7 of the 2006 Persons with Disability Act broadly provided that persons with disabilities should enjoy the same rights with others in all health and medical care institutions. It exempted health materials and equipment relating to disabilities from government levies, promoted the introduction of sign language in the curriculum for medical personnel, recruitment of interpreters in hospitals, and pre-brailed labels on drugs.[51] Imposing no obligations on the Ministry of Health, the law was repealed by the 2020 Persons with Disabilities Act.

The 2020 Persons with Disabilities Act ushered in major improvements in access to health services, domesticating article 25 of the CRPD.[52] Further, section 7 of the Act addresses non-discrimination against persons with disabilities in the provision of health services and is to the effect that:

> A health unit shall not discriminate against a person with a disability on the basis of the disability. The Unit shall comply with accessibility standards stipulated under section 10 of the Act; provide wheel chairs and accessible examination tables; provide labor beds for expectant women with disabilities.

These important components should be replicated in the National Policy on Reproductive Health of 2012 to promote inclusive access to MSRH services. Overall, disability inclusive policies on access to MSRH services requires the development of a number of strategies in order to guide the implementation of inclusive MSRH services for women with disabilities at all levels.

3.1 The national policies in relation to disability

Meeting the MSRH needs of women with disabilities has become an important public policy paradigm in many parts of the world, including in Uganda, over the past two decades. A number of policies, programmes

49 United Nations, Vienna Convention on the Law of Treaties, 1969, Treaty Series 1155, 331 art 19.
50 Kagaha & Manderson (n 48).
51 Persons with Disabilities Act, 2006, sec 7(2).
52 Art 25 of the CRPD provides that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. It further enjoins states parties to take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.

and legal frameworks have been designed to promote a friendly environment for safe motherhood, prevention of unintended pregnancies, safer sex and the reduction of maternal complications. Although is not a policy as such, the 1999 Uganda National Minimum Healthcare Package (UNMHCP), put in place a framework for the delivery of universal health coverage (UHC). Whilst this has been replaced by the 2024 National Essential Health Care Package for Uganda, priority is still given to the delivery of maternal health services rather than disability.[53]

The National Policy on Disability was adopted in January 2006 to guide and inform the planning process, resource allocation, implementation, monitoring and evaluation for activities with respect to persons with disabilities.[54] The major aim of this policy is to promote equal opportunities for enhanced empowerment, participation and protection of the fundamental rights and freedoms of persons with disabilities irrespective of gender and age. Although the policy has a section on health, it does not prescribe adequate access to MSRH services for persons with disabilities. This omission is problematic as it fails to offer guidance during service provision, ensure resource allocation, monitoring and evaluation of activities on access to MSRH services for persons with disabilities. This shortcoming may be attributed to the fact that the policy predates the CRPD, and hence does not consider the provisions of article 25 on reproductive health services that accommodate the needs of women with disabilities.

The 2010 Second National Health Policy refers to persons with disabilities only three times: first, in the list of acronyms as PWD; second, in respect to the physical access to health centres; and third, around lack of material for assistive devices. The policy fails to prioritise disability in the universal access to healthcare, yet disability may be aggravated by poor health or be prevented upon earlier diagnosis. Focusing the Policy on health promotion, disease prevention and early diagnosis and treatment, and categorising persons with disabilities among broader vulnerable groups, fails to address their unique health needs. None of the district health provision guidelines mention disability inclusion. The failure to mainstream disability in the entire policy contravenes the aspirations of the CRPD, especially article 25 on health, including MSRH services. This lacuna also explains the reasons for lack of prioritisation of disability in healthcare, lack of disability inclusive budgeting and the associated policy barriers that limit physical and information access to the health infrastructure and service delivery.

53 National Essential Health Care Package for Uganda, August 2024, sec 4.9.
54 Government of Uganda 'National policy on disability' (January 2006).

The 2011 National Physical Planning Guidelines and Standards[55] require having ramps and designated parking at public buildings such as schools and hospitals. However, it is unclear what steps the Ministry of Lands, Housing and Urban Development has taken to budget for and implement these guidelines.

3.2 The 2012 national reproductive health policy and service standards: The national policy guidelines for sexual and reproductive health services

The first Family Planning and Maternal Health Policy was developed in 1993.[56] The second edition of the policy was developed in 2001 to domesticate the recommendations of the ICPD of 1994 that recommended the comprehensive SRH components.[57] Subsequently, the current 2012 National Policy Guidelines for Sexual and Reproductive Health Services and Service Standard was developed to address technological updates, emerging issues such as new-born care, and sexual gender-based violence.[58]

Overall, the policy aims to improve SRHRs for all citizens of Uganda. This, it states, is through guided planning, implementation, monitoring and evaluation of quality integrated reproductive health services. These are to include the standardisation of the delivery of services, the optimisation of the use of resources for the sustainability of MSRH services, and the promotion of SRH services.[59] To guide the delivery of quality integrated SRH services from the community up to the national level, the policy makes no reference to disability, nor representation of organisations of persons with disabilities. This implies that women with disabilities were barely involved and consulted throughout all the processes of developing the policy. This oversight is inexcusable because, four years before the policy was enacted, Uganda had ratified the CRPD without reservations, therefore accepting to take all effective and appropriate measures to promote disability inclusion in all legal, policy and administrative frameworks as outlined under article 25.

Regrettably, for a number of reasons, the policy therefore fails to guide resource allocation, monitoring and implementation of MSRH programmers for the holistic protection, promotion and fulfilment of the

55 Uganda Ministry of Housing, Planning & Urban Development 'National physical planning guidelines and standards' (2011).
56 Uganda Ministry of Health 'National policy guidelines and service standards for sexual and reproductive health and rights' (2006) https://library.health.go.ug/ (accessed 10 September 2024).
57 As above.
58 Uganda Ministry of Health 'National policy guidelines for sexual and reproductive health services and service standards' (2012).
59 Uganda Ministry of Health 'National policy on reproductive health' (2012).

rights of women with disabilities. First, while the policy mentions other marginalised groups, such as women adolescents, women with disabilities were left out. Second, the policy fails to incorporate disability in the health workers' training curriculum. Third, although the CRPD makes informed consent mandatory for persons with disabilities accessing SRH services, the policy does not emphasise the respect of their rights, needs, will and preferences. Any policy review, therefore, must outrightly uphold the self-determination of persons with disability. Informed consent of women with disabilities must precede, for instance, undertaking major medical procedures such as tubal ligation, sterilisation and abortion. Fourth, although the policy guarantees access to reproductive health services for all, women with disabilities in Uganda face multiple forms of discrimination while accessing reproductive health services. Safe motherhood, prenatal and postnatal care, remain a big challenge for women and girls with disabilities. Fifth, the Policy fails to emphasise the need to facilitate strict communication measures, such as, regional and national availability of sign language interpreters at all community health centres, the provision of braille and large print, or audio for prescriptions, or alternative communication for persons with intellectual and psychosocial disabilities (plain and simple language, pictures or symbols). Sixth, although the policy guarantees capacity building programmes to address new issues around access to MSRH services, it does not build the knowledge base for nurses and midwives on the reasonable accommodation as required by CRPD and the ICPD. Finally, the policy does not guide the Ministry of Health to allocate resources to persons with disabilities. Clearly, meeting the needs of women with disabilities desiring access to MSRH services comes with cost implications, without which catering for their needs becomes complicated and untenable.

Following a consultative process, the 2023 National Policy for Persons with Disability adopted a human rights approach towards disability inclusion and prioritised access to MSRH services with actions for its implementation.[60] Section 5.2 of the Policy incorporates the constitutional provisions as well as the Persons with Disabilities Act, 2020, with emphasis on the protection of the rights of persons with disabilities. Under sections 4.6 and 4.7, it domesticates the CRPD by including the principles of accessibility, non-discrimination, respect for the inherent dignity, autonomy and independence of persons with disabilities, acceptance of disability as part of human diversity and difference, equality between men and women, equality of opportunities, and respect for the views of children with disabilities. It recognises the existing exclusion and vulnerability of persons with disabilities under section 3.3. Therefore, sections 3.4 and 3.5 address the barriers experienced in accessing MSRH services and recommends a situation analysis that pays particular attention to the

60 Uganda Ministry of Labour, Gender and Social Development, 'National policy for persons with disability' (2023) 15, supported through Technical Working Groups at national level.

challenges faced by women with disabilities. Importantly, it provides a budget framework for the allocation of resources towards disability inclusion.

4 Findings on the implementation of inclusive access to MSRH services for women with disabilities

The above legal and policy framework notwithstanding, there is a disconnect between the ideals of the law and the lived reality of women with disability. Field research reveals that diverse barriers result in women with disabilities receiving only a fraction of MSRH services. This paper highlights the weaknesses in 'reasonable accommodation' of disability through a two-pronged analysis of accessibility that addresses information and communication, physical accessibility and social acceptation in terms of stereotypes and sexuality dilemmas.

4.1 Weak policy guidelines and strategies for the inclusion of women with disabilities during access to MSRH services

Almost all the respondents from the key informant interviews decried the lack of a deliberate policy directive on MSRH that mainstreams the needs of persons with disabilities. A government representative observed:

> Although some aspects of the National Development Plan (NDP) III and the reproductive health guidelines and service standards are not discriminative, they do not have clear indicators or strategies on how we should address disability during the provision of MSRH Services.[61]

The lack of clear guidance has compounded the lack of harmonised practice and diverging views regarding prioritising women with disabilities at the health centres.

4.2 Budgetary implication

MSRH service providers affirmed that daily they meet with different categories of women with disabilities seeking antenatal services, pregnancy tests, management and treatment of sexually transmitted diseases and infections, and counselling and guidance resulting from domestic violence.

According to the respondent from the Ministry of Gender, 'many women with disabilities are poor and therefore cannot afford to pay for

61 Ministry of Health, Kampala.

MSRH Services'. A midwife noted, 'some MSRH Services are not available at the health centres and they require payment of some money to get them', and yet 'women with disabilities are usually very poor and neglected by their relatives that they cannot afford to pay for the services'.[62]

4.3 Reasonable accommodation

Women with disabilities present unique needs during access to MSRH services, making their consultations in the design of policies and programmes related to MSRH services imperative.[63] It is noteworthy that the CRPD Committee has constantly reiterated the mandatory obligations of state parties to undertake consultation of wide diversity of persons with disabilities, right from initiation of the policy to implementation.[64]

There are divergent views over the quality of the consultations. Some agree that the government holds consultations with women with disabilities themselves, their representative organisations and caregivers whenever new programmes are introduced.[65] Another respondent from an Organisation of Persons with Disabilities (OPD), observed:

> In 2017, women with disabilities were invited to be part of the review of the national guidelines and services standards of reproductive health. However, whenever we present our issues, they are never considered.[66]

Similarly, another respondent from the NCPD indicated that disabled people's organisations are not consulted whenever government introduces new programmes. According to the respondent:

> Particularly in the area of maternal, sexual and reproductive health, I am not sure whether women with disabilities and their representative organizations have been consulted. Whenever I went to the hospital, they just took me like an ordinary woman.[67]

In the study, the interviewed respondents from organisations of persons with disabilities say that consultations are technically done as public

62 Gwatiro Health Centre.
63 UN '11th session of the Conference of States Parties to the CRPD, 12-14 June 2018' https://www.un.org/development/desa/disabilities/conference-of-states-parties-to-the-convention-on-the-rights-of-persons-with-disabilities-2/cosp11.html (accessed 3 September 2024).
64 CRPD Committee, General Comment 7 on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, 9 November 2018, UN Doc CRPD/C/CG/7 (2018).
65 Interview with an official from the Ministry of Gender, held at her office in Kampala on 30 September 2022.
66 Interview with a key informant from Uganda National Action for Persons with Physical Disabilities at their office in Kampala, October 2021.
67 National Council for Persons with Disabilities, at their offices in Kireka.

relations gimmicks with hardly any follow-up of the recommendations of persons with disabilities.

4.4 Appropriateness of MSRH services to the needs of women with disabilities

The lack of guidelines and requisite resources has also adversely shaped the inappropriateness and ad-hoc nature of MSRH services offered to persons with disabilities and their needs in respect to communication and physical accessibility. A respondent in the doctoral study from the Uganda National Association of the Deaf, in Mukono, said that maternal healthcare services are under-budgeted and cannot take care of sign language interpreters to provide sign language during anti-natal and postnatal care.

4.5 Participation, communication and self-determination

One of the indices of participation is mutual and effective communication. However, a gynaecologist respondent found it challenging that he could not communicate with expectant women with hearing impairments because he did not know sign language.[68] Clearly, without sign language interpreters, persons with hearing impairments struggle to make their needs known to MSRH service providers. With no sign language interpreters, health workers address the person escorting the hearing-impaired person, denying them the opportunity to express themselves about their unique needs. Similarly, health workers tend to bypass persons with vision or hearing disability in consultations about their health needs.[69]

Indeed, health workers provide prescriptions of medicine in print form which visually impaired cannot read without assistance.[70] Lack of accessible formats means that the visually-impaired patients, or persons with psychosocial and intellectual disabilities struggle to understand the available services.

A respondent from Marie Stopes, specialising in providing contraception and family planning services, observed that most of the MSRH decisions are influenced by support persons and caregivers of persons with disabilities under the pretext that is very difficult to obtain consent from them.[71]

68 Interview at Bombo Military Hospital, 14 October 2021.
69 Interview with a respondent from Show Abilities Uganda, at her office in Kampala on 29 September 2022.
70 Interview with a Youth with Visual Disability on 5 October 2021.
71 Interview with a respondent from Marie Stopes.

4.6 Physical accessibility

Many facilities lack the requisite equipment to enable access to the built environment, information and communication to persons with disabilities seeking MSRH services. A medical gynaecologist at Bombo Medical Centre complained that examining persons with physical disabilities is often a challenge, '[w]e did not have examination beds that lower down and go up. I needed support to lift her up and bring her down'. Nurses also observed that the health facilities are full of staircases that lack ramps for wheelchairs and crutches for persons with physical disabilities. Likewise, a key informant from the umbrella organisation for persons with disabilities noted that, in the absence of accessible labour beds, mothers with physical disabilities end up delivering on the floor. Indeed, although some women with disabilities are unable to walk to health centres, there are no community channels to deliver home-based services such as family planning, antenatal and other related services.[72] Uganda lacks mobile clinics that could deliver family planning services, including contraceptives, as well as MSRH services.[73]

As a potential legal precedence, in the case *Nyeko Okello and Santo Dwoka v Centenary Rural Development Bank Limited* in 2022**,** the plaintiffs (both with disabilities) sued the bank on the grounds that the lack of ramps prevented their access to its main banking hall.[74] Afraid of the potential court settlement, the bank rapidly constructed the ramps, allowing the plaintiffs to settle the matter out of court. Such a precedence perhaps acts to prompt the Government of Uganda to ensure that all health centres have ramps.

4.7 Stereotypes and attitudes

Stigma and discrimination associated with disability still persist in Uganda today. Societal attitudes about access to MSRH services by women with disabilities clearly affects the doctor-patient relationships. The research finding reveals that a recognisable number of health workers do not want to provide MSRH services to women with disabilities because of the negative assumptions they have about disability. As one respondent noted: 'When health workers see Women with Disabilities approaching the health centres, they disappear because they do not want to serve them or find it difficult to'.[75]

72 As above.
73 Interview with Diana, a respondent from NUDIPU on 2 September 2021.
74 Civil Suit 23 of 2008.
75 Interview with a respondent from the disability movement on 10 October 2021.

In the 2011 case *Centre for Health, Human Rights and Development and Iga Daniel v Attorney General,*[76] a petition was filed in the Constitutional Court in light of the derogatory language used in most of Uganda's legal framework. The Constitutional Court found that the words 'idiot and imbecile' that appear in sections 130 of the Penal Code Act contravened articles 20, 21, 23, 24, 33 and 35 of the Constitution by reason of their being derogatory, dehumanising and degrading, and accordingly struck them out from the statute books. The case is instructive on unacceptable language not to be used by health service providers while providing treatment to persons with disabilities.

Indeed, health workers without disabilities generally present very negative attitudes towards women with disabilities, have limited knowledge and capacity on disability mainstreaming and inclusion, stigma and discrimination. For example, they keep women with disabilities in long queues or shout at them and rebuke them for seeking MSRH services. Likewise, escorts of expectant mothers with disabilities are often perceived as an irritant. A midwife observed, 'soldiers who escort their wives with disabilities keep knocking on the door say, I want to go, you are delaying me, and they put us on tension'.[77]

The idea of asexuality of women with disabilities cuts across many African and Asian societies.[78] Medical professionals and individuals within the community were often surprised when people with disabilities came to seek MSRH services.[79] A deaf informant from Kampala, narrated her experience of such obstetric violence during access to MSRH services:

> I am a woman with hearing impairment. I experienced labour pain and went to hospital, but health workers kept shouting at me, I didn't know what they were saying. I kept signing to inform them that I was in pain, but they just walked bypassed me, which I thought was discrimination resulting from their negative attitudes.[80]

There has also been a myth that Women with Disabilities in Uganda are virgins and therefore a cure to HIV/AIDS. In Nampewo's study on disability and sexuality in Uganda, respondents recount how men came to women with disabilities at night to have sexual intercourse with the view

76 Constitutional Petition 64 of 2011.
77 A key informant midwife from Bombo Military Hospital on 22 October 2021.
78 UN Women *Mapping of discrimination against women and girls with disabilities in East and Southern Africa* (2020) 81.
79 R Addlakha, J Price & S Heidari 'Disability and sexuality: Claiming sexual and reproductive rights' (2017) 25 *Reproductive Health Matters* 4.
80 Barbara, a deaf woman from Kampala.

to be cured of HIV/AIDS.[81] Here, persons with disabilities neither had sex by choice nor were issues of safe sex considered.[82]

4.8 Sexuality and stigma

In most of these legal frameworks, persons with disabilities have been left out and excluded due to myths and misconceptions that treat them as asexual and unable to bare children. According to a key informant from the Ministry of Education, 'many men who sexually relate with women with disabilities do not want to take up responsibility of their actions including relationships and pregnancies'.[83]

A key informant from the disabled people's organisation stated that health workers believe that it is wrong for persons with disabilities to have sex or to get pregnant. A key informant from Light for the World, an international disability NGO, recounted: 'There was a time I was in hospital and someone made a statement: "how did this happen that the husband and the wife are both blind! God is unfair"'. Such prejudicial statements discourage women with disabilities from accessing MSRH services.

A related challenge is the lack of choice and control over the methods of family planning. Respondents said that, on many occasions, young women and girls do not have a chance to make decisions about the methods of family planning they should utilise. A key informant from NUDIPU offices in Kampala explained:

> Health workers have predetermined attitudes. They think since you cannot talk, you cannot make MSRH related decisions. Often health workers end up making decisions for a woman with disability without consulting her.

However, women with disabilities experiences with MSRH services are not all negative.

4.8.1 Innovative strategies by health workers to provide quality MSRH services to women with disabilities

Nurses and gynaecologists with disabilities provide priority to women with disabilities because they have a personal understanding of the discrimination barriers experienced in accessing the health facility. One of the respondent nurses said:

81 Z Nampewo 'Young women with disabilities and access to HIV/AIDS interventions in Uganda' (2017) 25 *Reproductive Health Matters* 121.

82 B Guzu 'Experiences of gender-based violence against women and girls with disabilities: A case study of Uganda' Submission to the UN Committee on the rights and protection of Persons with disabilities.

83 Interviewed at the Crested Towers offices in Kampala on 20 October 2021

> Since many expectant mothers with disabilities come on boda boda (a motor cycle used in private transport at a fee) and experience waiting charges as a result of the long stay at the hospital, I try and serve them first to avoid these charges and the associated torture of keeping them for long.[84]

While striving to ensure the provision of quality services to women with disabilities, some health workers have taken a number of positive measures to actualise the practice of inclusive MSRH services. Such measures include: learning of sign language to facilitate communication with women with hearing impairments; provision of support to women with physical disabilities to access examination tables; sensitising fellow health workers to provide friendly MSRH services to women with psychosocial disabilities; and avoiding diagnostic overshadowing to different categories of women with disabilities.

A midwife key informant states that she has put in place mechanisms to support the Village Health Teams (VHTs) to deliberately identify women with disabilities in need of MSRH services and refer them to the facility. She stated:

> As a health worker, I have done mentorship to fellow service providers and continuous medical education called PMS where I take them through ways of handling mothers with disabilities by prioritizing them during the provision of MSRH services.[85]

Another midwife revealed that they have put a number of relevant MSRH services in one place for ease of access, including testing, immunisation, antenatal, and drug dispensation after prescription from the doctor.[86] Yet another nurse key informant says she has also taken steps to create rapport with women with disabilities who seek for MSRH services in order to build trust to discuss their concerns, enable them make informed MSRH decisions, and promote service delivery.[87]

5 Recommendations to promote inclusive access to MSRH services by women with disabilities

While acknowledging the progress ushered in the 2023 Persons with Disability Policy, it is too early to assess its impact. Hitherto, there has been a lack of attention and prioritisation of disability in most of the legal and policy frameworks on access to MSRH services, and in particular the Reproductive Health Policy of 2012. Simon Duffy's citizenship theory argues that, by focusing on the experiences of disabled people and other excluded groups, we can achieve a much better account of social justice for

84 Interview with a nurse from Mpenja Health Centre on 2 February 2022.
85 Interviewed at Gwatiro Health Centre in Kampala on 14 November 2022
86 Interviewed at Bombo Health Centre on 12 November 2022
87 Interviewed at Mpenja Health Centre in Mpigi on 30 October 2022.

everyone.[88] As a self-reflective process, therefore, it is critical to address the lived experiences of women with disabilities in accessing MSRH services. This is because of the way women with disabilities are perceived by society, which requires the designing of policies and public services with their involvement in order to lead to a fundamental change that promotes equal citizenship and promotes positive inclusion of persons with disabilities.[89] Person-centred planning is therefore is meant to address individual needs of women with disabilities using their experiences while simultaneously addressing their collective rights in accessing MSRH services.

The paper acknowledges government's positive action in putting in place an adolescent policy on MSRH. It therefore urges for a similar specific policy on MSRH services for women with disabilities to address their unique needs. It is lauded that the 2023 policy operationalises article 25 of the CRPD. The following recommendations are intended to breathe life into the legal and policy framework to improve the lived realities of women with disability.

5.1 Improve data collection to support budgetary allocation

In order to support adequate planning, implementation and monitoring of the delivery of MSRH services, there is need to improve the statistical data on the nature and numbers of women with disability. Additionally, policy guidelines must be supported with the necessary resources to implement inclusive MSRH programmes for women with disabilities. Although, in theory, MSRH services are planned, budgeted and implemented through the Third National Development Plan (NDP) III 2020-2025, this is not the case for persons with disability. As disability cuts across the delivery of MSRH services, targeted budgeting for disability should be mainstreamed in the design of all programmes and services.

As a starting point, the data collected at the health centres should be expanded from the indicators of male, female and residences, to include whether the patient has some form of disability. Further, equipping the VHTs to map and ascertain the numbers of women with disabilities within the reproductive age would augment the empirical data collection.

88 S Duffy 'The Citizenship Theory of social justice: Exploring the meaning of personalization for social workers' (2010) 24 *Journal of Social Work Practice* 253.

89 C Leadbeater 'Personalisation through participation: A new script for public services' (2004) https://static1.squarespace.com/static/6098eb1bb86d9454e6f1a0e6/t/61b758dc9c8cc34906647688/1639405789444/PersonalisationThroughParticipation.pdf (accessed 15 August 2020).

5.2 Participation of women with disabilities in the policy making bodies

Women with disabilities have lacked a voice at various levels of health care provision and attempts to identify and meet their needs have met with limited success.[90] As a general human rights principle, women with a disability have the right to participate in decisions that relate to them, to improve their appropriateness and relevance. The involvement of people with disability in the decision-making processes and in the delivery of services would foster fundamental and lasting change. As was rather tritely opined by the Minister in charge of disability, 'nothing about us without us' has been a slogan and integral message from the disability-rights movement for decades.

Hence, it is imperative to engage women with disability to participate in the review of related policy guidelines to incorporate the principles of the CRPD, such as inclusive MSRH services and reasonable accommodation, so as to promote tailor-made measures for comprehensive accessibility, awareness-raising and a twin-track approach that promotes disability mainstreaming alongside specific measures in the course of accessing MSRH services.

5.3 Training

Government has the primary responsibility to raise general public awareness about disability rights in order to build shared understanding of disability as a rock to engage with women with disabilities as inherent human beings. This would combat the negative stereotypes, deconstruct stigma, myths and misconceptions associated with disability. One of the strategies that could best help women with disabilities to access MSRH services is capacity building for health workers on the unique needs of women with disabilities and factors affecting their accessibility to MSRH services. This would foster positive mindset change to improve the attitudes of health workers towards women with disabilities.[91]

Incorporating disability rights within the curriculum and refresher training as well as the referral pathways of stakeholders is essential. Further, availing the contacts of the heads of the health facilities to be on call whenever persons with disabilities require MSRH services is a good strategy that would ensure that those in charge may instruct health workers

90 Report of the Special Rapporteur on the Rights of Persons with Disability 'Disability inclusive policies' (2016).

91 Interview with a respondent from a Disabled People's Organization on 11 September 2021 at the Uganda National Action of Persons with Physical Disability Offices (UNAPID) offices.

on duty to prioritise persons with disabilities during the provision of MSHR services.

5.4 Improve accessibility of MSRH to persons with disability

Accessibility is both a general principle applied across the CRPD as well as specifically provided under article 9. Accessibility is key for the autonomy, independence and dignity of persons with disabilities by ensuring that they can live independently and make choices on an equal basis with others; exercise their human rights and freedoms; and fully participate in all aspects of political, social, cultural and economic life.[92]

Accessibility entails both communication and physical accessibility. First, a key dimension of accessibility is effective communication. Information about laws, policies and services needs to be tailored to the different needs of people with disability to encourage them to seek out health services when a need arises as well as receive quality services. Further, the government should designate and remunerate sign language interpreters at each health centre to ease communication between health workers and persons with hearing disabilities. Second, accessibility entails physical accessibility and it involves the removal of physical barriers in the environment of MSRH services. In addition to enforcing the guidelines for having ramps and designated parking at public buildings, there is need to ensure the availability of adjustable beds at each health centre, assistive devices and wheelchairs to ease the movement of patients with disabilities.

6 Conclusion

This paper analyses the existing laws and policies in relation to access to MSRH services by persons with disabilities and presents the gaps therein. It notes the gaps in the implementation and enforcement of the policies and laws and also provides solutions and strategies to address the challenges that hinder persons with disabilities in accessing MSRH services. As a state party to the CRPD, Uganda has an obligation to undertake measures to ensure the availability and accessibility of inclusive MSRH services for persons with disabilities. Some of the measures would include training health service providers on the needs and rights of persons with disabilities.

This paper recommends a twin-track strategy of both mainstreaming disability in all MSRH policies and programmes, as well as having specific measures targeting women with disabilities to address their unique needs during access to MSRH services. The mainstreaming approach requires MSRH programmes to be fully accessible by paying attention to physical

92 BG Link & JC Phelan 'Conceptualizing stigma' (2001) 27 *Annual Review of Sociology* 363.

health facilities, MSRH information, removal of any other barriers, and the training of health service providers to enable them provide equitable access to MSRH services to persons with disabilities. Inclusion and participation of persons with disabilities in the design of policies is an effective strategy to address individual needs for reasonable accommodation as well as streamline enforcement. Public awareness raising is also recommended to deconstruct stigma and myths associated with disabilities and provides a platform for mindset change on the part of service providers.