

The Right to Sexual and Reproductive Health:
A scoping review of the experiences of persons with
disabilities in South Africa

A dissertation submitted in partial fulfilment of the requirements of Master of
Philosophy in Sexual and Reproductive Rights in Africa

By

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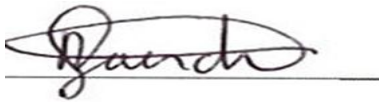
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Dedication

To my friend Goddess Saraswati. As a child, I have always navigated towards the Goddess of knowledge. She has been a great companion on my journey to enlightenment.

Om Jai Saraswati Mata, Jai Jai Saraswati Mata

To my parents, for inspiring me to be the best version of myself. I am grateful every day to have a progressive father who believed that girls have the right to education. Hence my quest to life-long learning continues....

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Acronyms

AAAQ	Accessibility, acceptability, availability, and quality
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral therapy
CEDAW	Convention on the Elimination of Discrimination Against Women
CESCR	Committee on Economic, Social, and Cultural Rights
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive sexuality education
DBE	Department of Basic Education
DoH	Department of Health
GBV	Gender-based violence
HCPs	Healthcare providers
HIV	Human Immunodeficiency Virus
HPV	Human papillomavirus
HTS	HIV Testing Services
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICF	International Classification of Functioning, Disability and Health
ICPD	International Conference on Population and Development
IPV	Intimate partner violence
LMICs	Low- and middle-income countries
MDGs	Millennium Development Goals
PCC	Population-Concept-Context
PoA	ICPD Plan of Action
SDGs	Sustainable Development Goals
SDM	Supported decision-making

SEM	Socio-Ecological Model
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRR	Sexual and reproductive rights
SSA	Sub-Saharan Africa
STIs	Sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Abstract

The 2030 Sustainable Development Agenda and its 17 Sustainable Development Goals promise to uphold the principle of inclusivity by ensuring that no one, including persons with disabilities, is left behind. However, societal and cultural beliefs have created stigmas and biases about persons with disabilities' sexuality and sexual and reproductive health, affecting their ability to realise their sexual and reproductive health and rights, which includes access to services, comprehensive sexuality education, and autonomy to make informed decisions. Sexual and reproductive health and rights policies and programmes overlook the needs of persons with disabilities in South Africa.

Using the Arksey and O'Malley framework, a scoping review was conducted to explore the experiences of persons with disabilities as they access sexual and reproductive health services in public healthcare facilities in South Africa.

The scoping review has shown that persons with disabilities experience structural, system and rights explicit barriers to accessing sexual and reproductive health services at public health facilities in South Africa. Structural and system barriers include the lack of trained healthcare providers in sign language, the unavailability of sign language interpreters, geographic constraints of health facilities, disability unfriendly infrastructure, and lack of adaptable equipment. The rights explicit barriers include stigma and discrimination, deprivation of sexual and reproductive health information, lack of respect for agency and autonomy. The inadequacy of disability-friendly infrastructure and accessible equipment underscores the failure to meet the reasonable accommodation and universal design requirements established by the Convention on the Rights of Persons with Disabilities, thereby hindering the promotion of disability inclusiveness in healthcare facilities that provide sexual and reproductive health services. This failure to address sexual and reproductive health and rights creates barriers to access. This study demonstrates that realising the right to sexual and reproductive health is intricately linked to the experience of accessing sexual and reproductive health services.

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Chapter 1. Introduction and background to the study

1.1 An International perspective on disability inclusive sexual and reproductive health rights

Globally, 1.3 billion people or 16 per cent of the world's population, experience significant disabilities.¹ Of these persons with disabilities, 80 per cent live in the Global South, where high rates of poverty, weak and fragmented healthcare systems, and extreme health disparities prevail.² Many persons with disabilities in the Global South belong to the most impoverished stratum of society, and face more frequent infringements on their rights in healthcare settings compared to others.³ According to Meekosha and Soldatic, the experiences of Persons with disabilities in the Global South are beyond the scope of human rights instruments.⁴ The United Nations (UN) Secretary-General, António Guterres, has emphasised that the full participation of Persons with disabilities is essential to achieving the Sustainable Development Goals (SDGs).⁵

The importance of including persons with disabilities in all aspects of society, including education, health, employment, and social services, was recognised in 1994 at the International Conference on Population and Development (ICPD) in Cairo.⁶ The ICPD redefined the global discourse on population and development issues,⁷ emphasising human dignity and rights as the core of sustainable development. In addition, the ICPD Programme of Action (PoA) urged States to focus on addressing the sexual and reproductive health (SRH) needs of persons with disabilities and eradicate discriminatory practices that hinder realisation of their sexual and reproductive health and rights (SRHR).⁸ Since the ICPD, those involved in SRH programming have firmly acknowledged the importance of human rights legal standards in the context of

¹ World Health Organization (WHO) 'Global Report on Health Equity for Persons with Disabilities' (2022), <https://www.who.int/publications/i/item/9789240063600> (accessed 7 March 2024).

² S Grech and others 'Intersecting disability and poverty in the Global South: Barriers to the localisation of the UNCPD' (2023) 11(4) *Social Inclusion* 326-337.

³ Grech and others (n 2) 326.

⁴ H Meekosha & K Soldatic 'Human rights and the Global South: The case of disability' (2011) 32(8) *Third World Quarterly* 1383-1397.

⁵ United Nations Department of Economic and Social Affairs 'Leaving no one behind - persons with disabilities and the SDGs' 3 December 2018, <https://www.un.org/uk/desa/leaving-no-one-behind-persons-disabilities-and-sdgs> (accessed 25 March 2024).

⁶ T Shakespeare and others 'Action, not words: Progress since the ICPD on disability and SRHR' (2019) 27 (1) *Sexual and Reproductive Health Matters* 340-342.

⁷ United Nations Population Fund (UNFPA) 'About the ICPD' 2024, <https://www.unfpa.org/icpd> (accessed 25 March 2024).

⁸ Shakespeare and others (n 6) 341.

SRH.⁹ Shakespeare and others argued that the ‘prophetic’ inclusion of disability in the ICPD PoA has seen the advancement of the human rights of persons with disabilities, evidenced by the 2008 Convention on the Rights of Persons with Disabilities (CPRD),¹⁰ which safeguards the dignity and rights of persons with disabilities.¹¹ To date, 185 countries have ratified the CPRD.¹²

The 2030 Sustainable Development Agenda and its 17 SDGs promise to uphold the principle of inclusivity by ensuring that no one, including persons with disabilities, is left behind.¹³ Shakespeare and others claim that, despite progress made since 1994, persons with disabilities still face challenges in accessing healthcare, such as negative attitudes from providers, mistreatment, communication barriers, lack of appropriate equipment, and disregard for their SRH needs.¹⁴ Persons with disabilities have been subjected to various SRHR violations such as sexual segregation, confinement, prohibition from marriage, and sterilisation disguised as protection from sexual abuse and pregnancy.¹⁵ The lack of recognition given to persons with disabilities regarding their SRHR also results in their exclusion from SRH services. The 2030 Sustainable Development Agenda acknowledges disability as an issue that cuts across all SDGs.¹⁶ In this regard, disability is relevant to implementing all the SDGs. Therefore, there is a need for action on disability inclusive SRHR.

SRHR is a crucial priority in the SDGs, reflecting the failure of the Millennium Development Goals (MDGs) to adequately address this issue.¹⁷ SRHR was consistently excluded from discussions on financing for development, and the absence of dedicated funding for SRHR was the primary cause of the failure to achieve the MDGs for girls and women.¹⁸ Explicit SRHR goals and targets can be found in the SDGs related to health, education, and gender equality.¹⁹ For example, target 3.7 of the SDGs aims to ensure universal access to SRH

⁹ R Brown and others ‘A sexual and reproductive health and rights journey: From Cairo to the present’ (2019) 27(1) *Sexual and Reproductive Health Matters* 326-328.

¹⁰ Shakespeare and others (n 6) 340.

¹¹ UNFPA ‘Disability inclusion in UNFPA programmes: Making it a reality’ 2023, <https://www.unfpa.org/sites/default/files/pub-pdf/DisabilityInclusionMakingItAReality-EN.pdf> (accessed 7 March 2024).

¹² World Bank Group ‘Disability Inclusion’ 2024, <https://www.worldbank.org/en/topic/disability> (accessed 17 May 2024).

¹³ AJ Galati ‘Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals’ (2015) 18(4) *Policy Review* 77-84.

¹⁴ Shakespeare and others (n 6) 341.

¹⁵ M Abwao and others ‘The disabled community is still waiting for equality’: What do users have to say about the sexual reproductive health of persons with disabilities in online news comments’ (2021) 6 *Frontiers in Communication* 1-13.

¹⁶ WHO Regional Office for Europe ‘Disability factsheet on Sustainable Development Goals (SDGs): Health targets’ 2019, <https://iris.who.int/handle/10665/340894> (accessed 21 March 2024).

¹⁷ Galati (n 13) 77.

¹⁸ B Shrestha ‘Financing sexual and reproductive health rights to realise sustainable development for women and girls’ 8 July 2015, <https://www.un.org/esa/ffd/ffd3/blog/financing-sexual-reproductive-health-rights.html> (accessed 15 May 2024).

¹⁹ Galati (n 13) 78.

services, including family planning, information, and education.²⁰ It also calls for the integration of reproductive health into national strategies and programmes by 2030. Of equal importance, target 5.6 of SDG 5 aims to achieve universal access to SRHR, as agreed in the ICPD PoA and the Beijing Platform of Action 1995. Access to SRH services, comprehensive sexuality education (CSE), and autonomy in making health-related decisions are essential elements within the SRHR domain.²¹ SRHR is crucial for sustainable development because of its association with gender equality and women's wellbeing,²² which in turn significantly impact maternal, newborn, child, and adolescent health, and shape future economic development and environmental sustainability.²³

Persons with disabilities have the same SRH needs and rights as persons without disabilities. However, for most of human history, the asexuality narrative has been prominent in their lives.²⁴ Societal and cultural beliefs have created stigmas and biases about persons with disabilities' sexuality and SRH needs, affecting their ability to realise their SRHR, which includes access to services, CSE and autonomy to make informed decisions.²⁵ This has led to their marginalisation and disregard and marginalisation of their SRH needs. Disability can intersect with other identities such as age, sexual orientation and gender identity, religion, ethnicity, socioeconomic status, and race.²⁶ This intersection of marginalised identities magnifies the disadvantages that people may experience, with persons with disabilities more likely to experience intersectional discrimination, exacerbating stigma, discrimination and the resulting violations of human rights.²⁷ Despite the codification of the right to non-discrimination by international human rights law, persons with disabilities experience intersectional discrimination when seeking SRH services or realising their SRHR.²⁸ The SDGs emphasise the importance of inclusive healthcare and diminishing disparities.²⁹ The failure to

²⁰ United Nations Department Economic and Social Affairs 'Family Planning and the 2030 Agenda for Sustainable Development Data Booklet', 2019
https://un.org/en/development/desa/population/publications/pdf/family/familyplanning_DataBooklet_2019pdf (accessed 18 March 2024)

²¹ Galati (n 13) 78.

²² AM Starrs and others 'Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission' (2018) 391 *Lancet* 2642.

²³ Starrs and others (n 22) 2652.

²⁴ E Kim 'Asexuality in disability narratives' (2011) 14(4) *Sexualities* 479-493.

²⁵ S Esmail and others 'Attitudes and perceptions towards disability and sexuality' (2010) 32(14) *Disability and Rehabilitation* 1148-1155.

²⁶ M Wickenden 'Disability and other identities? – how do they intersect' (2023) 4 *Frontiers in Rehabilitation* 1-6.

²⁷ As above, 2.

²⁸ M Mac-Seing and others 'The intersectional jeopardy of disability, gender, and sexual and reproductive health: Experiences and recommendations of women and men with disabilities in Northern Uganda' (2020) 28(2) *Sexual and Reproductive Health Matters* 1-15.

²⁹ J Shuáibu 'Sexual and reproductive healthcare must be disability inclusive' (2023) 328 *BMJ* 2395.

address the SRH needs of persons with disabilities may impede the attainment of the SDGs.³⁰ The goal of providing inclusive healthcare needs to become a reality.

1.2 Terminology

The definition of SRHR has evolved through the work of global public health, development and human rights advocates.³¹ From 2016 to 2018, 16 commissioners from Africa, Asia, Europe, the Middle East, North America, and Latin America with diverse expertise and experience in SRHR collaborated with researchers at the Guttmacher Institute (United States) and the African Population and Health Research Centre (Kenya) to develop a comprehensive and integrated definition of SRHR.³² The Guttmacher-Lancet Commission advanced the definition of SRHR through international and regional agreements, technical reports, and guidelines.³³ Within this context, it is essential to clearly understand the specific terms and vocabulary used in this study.

Human rights

Human rights are inalienable and apply to all individuals, regardless of their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or status.³⁴ These include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, and the right to work and education, among others.³⁵ The establishment of fundamental human rights, freedoms, and legal rights underpin access to SRH services.³⁶ Legal protection of human rights is essential to upholding dignity and ensuring survival.³⁷ Furthermore, human rights are intricately linked and interdependent, with the exercise of one right often reliant on the existence of others.³⁸

³⁰ As above, 2395.

³¹ Starr and others (n 22) 2644.

³² As above.

³³ As above.

³⁴ WHO 'Human Rights' 1 December 2023, <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> (accessed 21 March 2024).

³⁵ As above.

³⁶ J Kehler and others *Human rights toolkit: Strengthening community action to address stigma and discrimination for HIV and TB key and vulnerable populations* (Facilitators Manual) (2020) AIDS Foundation South Africa.

³⁷ As above, 9.

³⁸ As above.

Sexual and reproductive health

SRH refers to:

A state of complete physical, emotional, mental, and social well-being regarding all areas of sexuality and reproduction. It is not simply the absence of disease, dysfunction, or infirmity. Therefore, a positive approach towards sexuality and reproduction should acknowledge the importance of pleasurable sexual relationships, trust, and communication in promoting self-esteem and overall well-being. Every person has the right to self-determination and access to services that support their sexual and reproductive health.³⁹

Sexual and reproductive health and rights

SRHR is grounded in human rights. The integrated definition of SRHR sees the realisation of SRH as reliant on upholding the SRHR of every individual.⁴⁰ These rights include the following: respect for bodily integrity, privacy, and personal autonomy; the freedom to define one's sexuality, including sexual orientation, gender identity, and expression; the choice to decide on sexual activity (or not); the choice to select one's sexual partners; having safe and pleasurable sexual experiences; the choice of when and whom to marry; the decision whether, when, and how to have children, including the number and spacing; and access to necessary information, resources, services, and support to achieve all these rights throughout one's lifetime; free from discrimination, coercion, exploitation, and violence.⁴¹

SRH services

These include family planning, contraception, maternal and perinatal health, fertility care, prevention and treatment of STIs and HIV, abortion and post-abortion care, and the dissemination of health information.⁴² Adherence to public health and human rights standards are of paramount importance for SRH services to guarantee the availability, accessibility, acceptability, and quality of services within the context of the right to health framework.⁴³ SRH services must be accessible, available, acceptable, and of high quality for persons with

³⁹ Starr and others (n 22) 2646.

⁴⁰ As above.

⁴¹ As above.

⁴² J Hanass-Hancock and others 'Leaving no one behind feasibility case study: Applying the Breaking the Silence approach in comprehensive sexuality education for adolescents and young people with disabilities during the COVID-19 epidemic' June 2021, <https://www.samrc.ac.za/research-reports/leaving-no-one-behind-feasibility-case-study-applying-breaking-silence-approach> (accessed 17 June 2024)

⁴³ Starr and others (n 22) 2646.

disabilities, while preserving inclusiveness. National disability legislation should be established to protect the rights of persons with disabilities to access SRH.⁴⁴ Persons with disabilities should be included in decisions regarding the allocation of funding for SRHR to ensure that SRH services and products are accessible to them.⁴⁵ Reasonable accommodation and universal design promote disability inclusiveness by facilitating access to physical environments, transportation, facilities, and services.⁴⁶ Examples include constructing wheelchair-accessible buildings, providing sign language interpreters and offering adjustable equipment.⁴⁷ In addition, health information and CSE should be available and accessible in alternative formats such as Braille, audio, and sign language for persons with disabilities.⁴⁸ To be deemed acceptable, SRH services must be culturally appropriate and sensitive to the needs of persons with disabilities. Improving the quality of care in disability inclusive SRH services requires training healthcare providers (HCPs) on the specific care needs of persons with disabilities. These services should also be characterised by respect, equality, non-discrimination, and affordability.⁴⁹

SRHR services

These can encompass a wide range of SRH services, including those services that focus on rights-based approaches, prevention and management of violence, access to justice and CSE.⁵⁰

Disability

This is described by the CRPD as,

Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.⁵¹

⁴⁴ UNFPA 'The right to access: Regional strategic guidance to increase access to sexual and reproductive health rights (SRHR) for young persons with disabilities' October 2017, <https://esaro.unfpa.org/en/publications/right-access-regional-strategic-guidance-increase-access-sexual> and reproductive health (accessed 27 March 2024)

⁴⁵ As above, 21.

⁴⁶ As above, 64.

⁴⁷ As above, 67.

⁴⁸ As above, 28.

⁴⁹ Kehler and others (n 36) 16.

⁵⁰ UNFPA (n 44) 7.

⁵¹ Convention on the Rights of Persons with Disabilities (CRPD) *Resolution* (adopted 24 January 2007) GA A/RES/61/106.

Stigma

This refers to the negative perceptions, attitudes, and emotions that people hold toward individuals due to a specific characteristic, such as disability or HIV status leading to labelling, stereotyping, and social exclusion.⁵²

Discrimination

This occurs when people are treated unfairly or negatively because their characteristics or attributes may be different.⁵³ Unfair discrimination constitutes a violation of fundamental human rights. Article 2 of the CRPD defines discrimination as,

Any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.⁵⁴

Components of SRHR

Further to the definitions shared above, there are four integral components of SRHR: sexual health, sexual rights, reproductive health, and reproductive rights.

Sexual health

The World Health Organization (WHO) defines sexual health as:

A state of physical, emotional, mental, and social well-being that goes beyond the mere absence of disease, dysfunction, or infirmity. It involves having a positive and respectful attitude towards sexuality and sexual relationships, as well as the ability to enjoy pleasurable and safe sexual experiences that are free from coercion, discrimination, and violence. To achieve and maintain sexual health, it is essential to respect, protect, and fulfill the sexual rights of all individuals.⁵⁵

Sexual health services include comprehensive counselling and care for sexuality, sexual identity, and relationships, as well as prevention and management of sexually transmitted

⁵² Kehler and others (n 36) 29.

⁵³ As above.

⁵⁴ Art 2, CRPD.

⁵⁵ WHO 'Sexual health and its linkages to reproductive health: n operational approach' 2017, <https://www.who.int/publications-detail-redirect/978924151288> (accessed 7 March 2024)

infections (STIs), including HIV/AIDS and other diseases of the genitourinary system.⁵⁶ Additionally, they also cover psychosexual counselling, treatment of sexual dysfunction and disorders, and prevention and management of cancers of the reproductive system.⁵⁷

Reproductive health

This is defined as,

A state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.⁵⁸

Reproductive health, for example, for women, involves a life course approach from menarche, fertility, pregnancy, gynaecological conditions, and menopause.⁵⁹ Hence, everyone must have access to precise reproductive health information and services. Reproductive health should ensure that girls and women can manage their menstruation in a hygienic manner that allows for privacy, hygiene, and dignity.⁶⁰ An essential aspect of providing for reproductive health includes access to multisectoral services for preventing and responding to gender-based violence (GBV), such as intimate partner violence.⁶¹ Reproductive health also addresses contraception, which should be accessible, safe, effective, affordable, and acceptable.⁶² Antenatal care is part of the continuum of reproductive health.⁶³ Abortion services, including post-abortion care, are essential to reproductive health.⁶⁴ Lastly, individuals should be able to access services for the prevention, management, and treatment of infertility.⁶⁵

⁵⁶ Starr and others (n 22) 2645.

⁵⁶ As above.

⁵⁷ As above.

⁵⁸ United Nations General Assembly 'Transforming our world: the 2030 agenda for sustainable development. A/RES/70/1.' 21 October 2015, https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf (accessed 21 March 2024)

⁵⁹ GD Mishra 'A life course approach to reproductive health: Theory and methods' (2010) 65(2) *Maturitas* 92-97.

⁶⁰ Starr and others (n 22) 2645.

⁶¹ As above.

⁶² As above.

⁶³ As above.

⁶⁴ As above.

⁶⁵ As above.

Sexual rights

These can be described as follows:

The application of human rights to sexuality and sexual health. These rights ensure that everyone has the right to express and satisfy their sexuality, as well as enjoy sexual health while respecting the rights of others. Discrimination is not tolerated in this framework of protection.⁶⁶

Good sexual health is intrinsically linked to several rights: the right to life, liberty, autonomy and personal security; equality and non-discrimination; freedom from torture or cruel, inhuman or degrading treatment or punishment; privacy; the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, along with equality during and after marriage dissolution; the right to decide the number and spacing of children; access to the information, and education; and the right of freedom of opinion and expression; and the right effective remedies for violations of fundamental rights.⁶⁷

Reproductive rights

These are the fundamental human rights of all individuals and couples to make responsible and free decisions regarding the number, spacing, and timing of their children. They have the right to access information and the means to make informed choices about their reproductive health. Additionally, they are entitled to the highest possible standard of reproductive health care.⁶⁸ Individuals have the right to make decisions about their reproductive health without facing prejudice, violence, or coercion.⁶⁹ They also have the right to privacy, confidentiality, respect, and informed consent. Furthermore, everyone is entitled to equitable and mutually respectful gender relations.⁷⁰

⁶⁶ WHO (n 55) 3.

⁶⁷ World Association of Sexology. 'Declaration of sexual rights' 2014, http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf. (accessed 21 March 2024).

⁶⁸ Starr and others (n 22) 2645.

⁶⁹ As above.

⁷⁰ As above.

Sexual and reproductive rights

Sexual and reproductive rights (SRR) is another term used, and refers to:

Basic human rights that everyone is entitled to, regardless of their age, sex, gender, sexuality, gender identity and expression, HIV/TB status, disability and whether or not they are engaging in sex work or using drugs.⁷¹

Furthermore, SRR is characterised by the principles of bodily autonomy and individual agency.⁷²

1.3 A South African perspective on disability inclusive sexual and reproductive health rights

Data on disability prevalence is under-reported in South Africa due to stigma and poor reporting methods,⁷³ with prevalence reported at only 4.8 per cent in the 2022 General Household Survey.⁷⁴ The prevalence is higher in women (5.3 per cent) compared to men (4.2 per cent). South Africa's legal framework prohibits discrimination against persons with disabilities and safeguards their SRHR through the provisions in the 1996 Constitution.⁷⁵ However, persons with disabilities' ability to fully realise their human rights is compromised by intersecting and compounding factors of poverty, gender inequity, prejudice, violence, poor stewardship, ineffective management of district health systems, and insufficient information for planning, monitoring, and decision-making in South Africa.⁷⁶

The latest data indicate that South Africa is one of the most unequal countries in the world, with a Gini coefficient of around 0.67, which measures household income distribution.⁷⁷ Health service coverage is inequitable,⁷⁸ with the healthcare system divided into public and

⁷¹ Kehler and others (n 36) 6.

⁷² As above, 89.

⁷³ S Maart and others 'Disability prevalence - context matters: A descriptive community-based survey' (2019) 8 *Africa Journal of Disability* 1-8.

⁷⁴ Statistics South Africa 'Statistical Release P0318: General Household Survey 2022' 17 August 2023, <https://www.statssa.gov.za/publications/P0318/P03182022.pdf> (accessed 27th March 2024).

⁷⁵ J Hanass-Hancock and others 'Sexual and reproductive health rights and disability policy analysis: The South African case report' March 2021, <https://www.samrc.ac.za/sites/default/files/attachments/2022-09/BtS%20Policy%20Report%20-%20Sexual%20and%20Reproductive%20Health%20Disability%20Policy%20Analysis.pdf> (accessed 27 March 2024).

⁷⁶ Department of Health (DoH) 'Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021' May 2011, https://knowledgehub.health.gov.za/system/files/elibdownloads/202304/National%2520Integrated%2520SRHR%2520Policy_Final_2021.pdf (accessed 27 March 2024).

⁷⁷ I Valodia 'South Africa can't crack the inequality curse. Why, and what can be done' *The Conversation* 15 September 2023, <https://www.wits.ac.za/news/latest-news/opinion/2023/2023-09/south-africa-cant-crack-the-inequality-curse-why-and-what-can-be-done.html> (accessed 21 March 2024).

⁷⁸ As above.

private sectors. Approximately 84 per cent of South Africans are dependent on the public healthcare sector, which is plagued by a shortage of healthcare personnel, training, equipment, and medicines.⁷⁹ In contrast, 16 per cent of the population uses the private healthcare sector, which is well-resourced.⁸⁰

Persons with disabilities often face difficulties accessing essential human rights services, including healthcare in South Africa,⁸¹ which is a critical challenge because their healthcare needs often exceed those of persons without disabilities.⁸² Surveys, such as those conducted by Vergunst and others, show that persons with disabilities in rural South Africa in particular, have an unmet need for healthcare services.⁸³ Similarly, Kuper and Hanass-Handcock found that persons with disabilities experience greater levels of unmet health needs and a lack of disability inclusive services.⁸⁴ The COVID-19 pandemic exposed and compounded structural inequalities that further hindered persons with disabilities' access to health facilities, therapeutic interventions, and medication in South Africa.⁸⁵

In terms of SRH, a recent study found that adolescents and young people with disabilities are disproportionately underserved due to the inadequate implementation of disability inclusive SRHR in communities.⁸⁶ Their unaddressed SRH needs pose a significant threat to their health and wellbeing.⁸⁷ In an analysis of the predictors of sexual rights for persons with disabilities in South Africa, Carew and others found that prejudice and negative beliefs compromised disability inclusive sexual rights.⁸⁸ In South Africa, persons with disabilities have reported that HCPs often assume they are asexual.⁸⁹ These misconceptions about disability and sexuality frequently result in persons with disabilities' SRH needs being overlooked, resulting in a higher risk of harm, stigma and discrimination. Hanass-Handcock

⁷⁹ K Govender and others 'Primary healthcare seeking behaviour of low-income patients across the public and private health sectors in South Africa' (2021) 1649 *BMC Public Health* 1-11.

⁸⁰ As above, 3.

⁸¹ S Blose and others 'Community-based rehabilitation implementation for people with disabilities in South Africa: A protocol for a scoping review' (2019) 1 (279) *BMC Systematic Review* 1-5.

⁸² H Kuper and J Hanass-Handcock 'Framing the debate on how to achieve equitable healthcare for persons with disabilities in South Africa' in H Kathard and others (eds) *South African Health Review* (2020) 45.

⁸³ R Vergunst and others 'Access to healthcare for persons with disabilities in rural South Africa' (2017) 17(141) *BMC Health Services Research* 1-8.

⁸⁴ Kuper and Hanass-Handcock (n 82) 46.

⁸⁵ EL McKinney and others 'Access to healthcare for people with disabilities in South Africa: Bad at any time, worse during COVID-19?' (2021) 63(1) *South African Family Practice*.

⁸⁶ B Mathabela and others 'Exploring barriers to accessing sexual and reproductive health services among adolescents and young people in South Africa' (2024) 21(2) *International Journal of Environmental and Public Health* 1-19.

⁸⁷ As above, 2.

⁸⁸ MT Carew and others 'Predictors of negative beliefs toward the sexual rights and perceived sexual healthcare needs of people with physical disabilities in South Africa' (2020) 24(23) *Disability and Rehabilitation* 3664-3672.

⁸⁹ X Hunt and others 'Sexual and reproductive health: Layers of (in)access' in X Hunt and others (eds) *Physical disability and sexuality* (2021) 116.

and others recommend linking and integrating SRHR into disability policies and strategies within South Africa.⁹⁰

1.4 Problem statement

The SRHR of persons with disabilities is often neglected in low- and middle-income countries (LMICs).⁹¹ Beyene and others report that women with disabilities have a low prevalence of contraceptive usage and high unmet contraceptive needs in LMICs.⁹² Despite South Africa's progressive legislation and policies aimed at facilitating access to SRH services, persons with disabilities have unmet SRH needs.⁹³ Adolescents and young people with disabilities may become sexually active and explore their sexuality at the same early age and frequency as their peers without disabilities,⁹⁴ yet the ongoing discrimination, exclusion, and limited access to SRH services could lead to high-risk sexual behaviour.⁹⁵ Persons with disabilities are vulnerable to SRHR violations, such as sexual abuse, GBV, unsafe abortions, forced or coerced sterilisation, forced contraception, abusive maternal healthcare, denial of maternity or parenting rights, denial of legal capacity and decision-making, inaccurate stereotypical views by HCPs, and lack of access to information and education on SRH.⁹⁶ This lack of access also exposes them to unplanned pregnancies, HIV/AIDS, and other STIs.⁹⁷

Hunt and others report a lack of SRH services tailored to persons with disabilities' needs in South Africa.⁹⁸ This hinders their access to comprehensive SRH information, care, and support, ultimately compromising their sexual and reproductive health, wellbeing and autonomy. The scarcity of inclusive SRH services has a detrimental impact on persons without disabilities; this is therefore compounded exponentially for persons with disabilities in South Africa. There is a crucial need for equitable and non-discriminative SRH service coverage for persons with disabilities in South Africa. However, there is limited research on SRHR and

⁹⁰ Hanass-Hancock and others (n 75) 8.

⁹¹ S Kakchapati and others 'Factors associated with access to sexual and reproductive health services among women with disabilities in Nepal' (2022) *Dialogues in Health* 1-6.

⁹² KM Beyene and others 'Factors affecting utilisation of modern contraceptive methods among women of reproductive age in Ethiopia' (2023) 18(11) *PLOS One* 1-12.

⁹³ Mathabela and others (n 86) 1.

⁹⁴ UNFPA (n 44).

⁹⁵ AG Mekonnen and others 'Determinants of knowledge, attitudes, and practices in relation to HIV/AIDS and other STIs among people with disabilities in North Shewa zone, Ethiopia' (2020) 15(10) *PLOS One* 1-13.

⁹⁶ UNFPA (n 44) 28.

⁹⁷ BK Rade and others 'Prevalence and factors associated with sexual and reproductive health services use among reproductive age women with disabilities: A community-based cross-sectional study' (2023) 23(1) *BMC Women's Health* 2-11.

⁹⁸ Hunt and others (n 89) 118.

disability to guide policy amendments and development.⁹⁹ Against this backdrop, this study explores the right to SRH and the experiences of persons with disabilities in South Africa.

1.5 Research questions

Primary research question

How does the right to sexual and reproductive health (SRH) intersect with the experiences of persons with disabilities as they access sexual and reproductive health services in public healthcare facilities?

Secondary research questions

1. How do persons with disabilities experience access to SRH in public healthcare settings?
2. What are the challenges persons with disabilities experience in accessing SRHR services?
3. What are the State's obligations to facilitate persons with disabilities' access to SRHR?
4. Does the content in SRH policies and strategic frameworks include persons with disabilities?
5. What are the gaps in the identified policies and strategic frameworks regarding the SRHR of persons with disabilities?

1.6 Research methodology

Multimethod qualitative research approach

The study employed a multimethod qualitative research approach. Multimethod studies aim to provide solutions to intricate social research inquiries.¹⁰⁰ The use of this approach has had a significant impact on anthropology and programme evaluation.¹⁰¹ This research approach uses either multiple qualitative or quantitative methods.¹⁰² In contrast, mixed methods studies use a combination of qualitative and quantitative methods.¹⁰³ This study was comprised of a desktop review of primary sources, including international and regional human rights instruments,

⁹⁹ Hanass-Hancock and others (n 75) 11.

¹⁰⁰ MT Anguerra and others 'Revisiting the difference between mixed methods and multimethods: Is it all in the name' (2018) 52 *Quality and Quantity* 2757-2770.

¹⁰¹ As above, 2756.

¹⁰² As above, 2577.

¹⁰³ J Schoonenboom & RB Johnson 'How to construct a mixed methods research design' (2017) *Kolner Zeitschrift für Soziologie und Sozialpsychologie* 69(2) 107-131.

national legislation, and policy frameworks related to SRH services and persons with disabilities, as well as their access to such services. A scoping review explored the experiences of persons with disabilities in accessing SRH services in public healthcare settings, including the challenges and barriers they encounter.

Scoping reviews are a method of synthesising knowledge to provide insights for developing practices, programmes, policies, and future research.¹⁰⁴ A study by Tricco and others found that 53 per cent of scoping review end-users were government officials and policymakers.¹⁰⁵ Arksey and O'Malley propose the earliest definition of scoping reviews:

Scoping studies aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available and can be undertaken as standalone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before.¹⁰⁶

Colquhoun and others expanded this definition, recommending the following:

A scoping review or scoping study is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge.¹⁰⁷

Chapter 3 presents a comprehensive overview of the scoping review, covering the methodology, findings and discussion. The data extracted from the studies were coded and synthesised using deductive qualitative content analysis and mapped onto the dimensions of Penchansky and Thomas' theory of access.¹⁰⁸

1.7. Significance of the research

Disability inclusive SRH is an under-researched topic in South Africa. Persons with disabilities, as rights holders, are entitled to accessible, dignified, equitable, and respectful SRH services. This study provides insight into how persons with disabilities experience SRH services in South Africa and highlights the challenges and barriers they encounter when

¹⁰⁴ H Colquhoun and others 'Scoping reviews: Time for clarity in definition, methods and reporting' (2014) 67(12) *Journal of Clinical Epidemiology* 1291-1294.

¹⁰⁵ AC Tricco and others 'A scoping review on the conduct and reporting of scoping reviews' (2016) *BMC Research Methodology* 16(15) 1-10.

¹⁰⁶ H Arksey & L O'Malley 'Scoping studies: towards methodological framework' (2005) 8 *International Journal of Social Research Methods* 19.

¹⁰⁷ Colquhoun and others (n 104) 1292.

¹⁰⁸ R Penchansky & R Thomas 'The concept of access: Definition and relationship to consumer satisfaction' (1981) 11(2) *Medical Care* 127-140.

accessing them. The findings of the study have significant implications for improving SRHR for persons with disabilities in South Africa, impacting policy, practice, quality of service delivery, and further research.

1.8. Literature review

The literature review provided an overview of issues pertaining to SRH within the context of disability. It identified the socio-ecological factors that influence access to SRH services, and explored different models of disability to better understand the conceptualisation of disability.

1.8.1 SRH issues

Global SRH issues include STIs, HIV/AIDS, unintended pregnancies, child marriage, adolescent pregnancies, maternal deaths, unsafe abortions, forced sterilisation, gynaecologic cancers, urogenital cancers, infertility, female genital mutilation, erectile dysfunction, and GBV. Women and girls are disproportionately affected by SRH ill health.¹⁰⁹ Persons with disabilities are also susceptible to SRH issues.¹¹⁰ Bukuluki and others found that adolescents and young people with disabilities engage in high-risk sexual behaviour, such as multiple sexual partners, sex without condoms, and transactional sex.¹¹¹ These behaviours increase the risk of unplanned pregnancies, and STI and HIV infection.

HIV/AIDS and STIs

HIV/AIDS is a major global health issue, ranking among the top ten diseases with the highest burden worldwide.¹¹² Unfortunately, access to treatment is not available to everyone.¹¹³ In 2022, 39 million people were living with HIV worldwide.¹¹⁴ Of these, only 29.8 million were accessing anti-retroviral therapy (ART).¹¹⁵ Additionally, there were 630,000 deaths due to AIDS-related illness. Africa has 25.6 million HIV cases, 65 per cent of the global total,¹¹⁶ and

¹⁰⁹ GN Mihretie and others 'Sexual and reproductive health issues and associated factors among female night school students in Amhara Region, Ethiopia: An institution based cross-sectional study' (2023) 13(7) *BMJ Open* 1-8.

¹¹⁰ Rade and others (n 97) 6.

¹¹¹ P Bukuluki and others 'The sexual behaviour of young people living with a disability: Findings from the KAP study in Northern Uganda' (2023) 5 *Frontiers in Reproductive Health* 1-12.

¹¹² TI Chen and others 'Global, regional, and national HIV/AIDS disease burden levels and trends in 1990-2019: A systematic analysis for global burden of disease 2019 study' (2023) 11 *Frontiers in Public Health* 1-17.

¹¹³ As above, 2.

¹¹⁴ UNAIDS 'Global HIV&AIDS statistics factsheet' 13 July 2023, https://www.unaids.org/en/resources/documents/2023/UNAIDS_FactSheet (accessed 9 April 2024)

¹¹⁵ As above.

¹¹⁶ WHO Africa Region 'HIV/AIDS' 2023, <https://www.afro.who.int/health-topics/hivaidsEpidemiology> (accessed 19 May 2024)

of the 630,000 global deaths, 380,000 occurred on the continent.¹¹⁷ South Africa is the epicentre of the HIV epidemic, with 13.8 per cent of people living with the virus.¹¹⁸

The rate of HIV infection among persons with disabilities may be higher than those without disabilities.¹¹⁹ Available data for Sub-Saharan Africa (SSA) indicates that the risk of contracting HIV is 1.48 times higher in men with disabilities and 2.21 times higher in women with disabilities than in those without disabilities.¹²⁰ Due to the perception of persons with disabilities as asexual, they may not access testing, be aware of their HIV status, and are less likely to access ART.¹²¹ A 2019 study in South Africa found that 16.7 per cent of persons with disabilities were living with HIV out of a sample size of 1348.¹²² Persons with disabilities are often excluded from HIV and STI prevention and treatment programmes, leaving them vulnerable to infection, among other risks.¹²³ Furthermore, persons with disabilities may face specific barriers when accessing services. For example, those with visual impairments may have limited access to HIV/AIDS information, while those with physical impairments may have difficulty accessing healthcare services.¹²⁴ Moreover, prejudices held by HCPs may further marginalise persons with disabilities.¹²⁵ These barriers can hinder the effective prevention and treatment of HIV/AIDS among persons with disabilities.

HIV related disability is increasingly recognised as a serious public health concern in hyper-endemic countries.¹²⁶ In 2015, Hanass-Hancock and others published a study in which they described that the experiences of living with HIV is influenced by the intersection of HIV, disability and gender in South Africa.¹²⁷ The research findings indicates that women living with HIV experienced a decline in social support and encountered partner abandonment

¹¹⁷ As above, 2.

¹¹⁸ A Vandormael and others 'The state of the HIV epidemic of rural KwaZulu-Natal, South Africa: A novel application of disease metrics to assess trajectories and highlight areas for intervention' (2020) 49(1) *International Journal of Epidemiology* 666-675.

¹¹⁹ S Pengpid & Karl Peltzer 'HIV status, knowledge, attitudes and behaviour with and without disability in South Africa: Evidence from a national population-based survey' (2019) *Pan African Medical Journal* 33(302) 1-6.

¹²⁰ UNAIDS 'Disability and HIV' 2017, https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf (accessed 17 June 2024).

¹²¹ D Chipanta and others 'Differences between persons with and without disability in HIV prevalence, testing, treatment, and care cascade in Tanzania: A cross-sectional study using population-based data.' (2023) 23 *BMC Public Health* 1-11.

¹²² Pengpid & Peltzer (n 119) 1.

¹²³ I Shale 'Sexual and reproductive health rights of women with disabilities: Implementing international human rights standards in Lesotho' (2015) 3 *African Disability Rights Yearbook* 31-62.

¹²⁴ HEARD 'Policy Brief: National response to disability and HIV in Eastern and Southern Africa' February 2010, <https://www.heard.org.za/publications-post/national-response-to-disability-and-hiv-in-eastern-and-southern-africa/> (accessed 17 June 2024).

¹²⁵ As above, 1.

¹²⁶ J Hanass-Hancock and others 'When I was no longer able to see and walk, that is when I was most affected: experiences of disability in people living with HIV in South Africa' (2015) 37 (22) *Disability and Rehabilitation* 2051-2060

¹²⁷ As above, 2052

following the onset of disability.¹²⁸ Conversely, men living with HIV reported experiencing a perceived reduction of masculinity and social standing upon becoming dependant on female family members for care due to disability.¹²⁹ Overtime, HIV-induced physical limitations and subsequent mobility restrictions significantly impede individuals' ability to access healthcare services and maintain adherence to antiretroviral regimens.¹³⁰

Every year, approximately 374 million new cases of STIs are reported worldwide.¹³¹ The most common are syphilis, chlamydia, gonorrhoea, trichomoniasis, and genital herpes.¹³² It is estimated that SSA accounts for 40 per cent of the total global prevalence of STIs.¹³³ Wand and others report that South Africa has the highest STI burden globally.¹³⁴ Moreover, South Africa is experiencing a twin epidemic of HIV and other STIs. A prevalence study in KwaZulu Natal, found that 20 per cent of 9948 women participating in an HIV biomedical intervention trial were diagnosed with an STI infection at baseline.¹³⁵ There is a paucity of data on the prevalence of STIs among persons with disabilities at global, regional, and national levels.

STIs adversely influence tubal factor infertility, pelvic inflammatory disease, and ectopic pregnancy. Moreover, they increase the risk of HIV infection. Human papillomavirus (HPV) is the leading cause of cervical cancer in females and anal cancer in men who have sex with men.¹³⁶ Mother-to-child transmission of STIs can lead to serious health complications for the newborn, including stillbirth, neonatal death, low birth weight, prematurity, sepsis, neonatal conjunctivitis, and congenital deformities.¹³⁷

Unintended pregnancies/unmet need for contraceptives

Unintended pregnancies are a significant public and reproductive health concern globally,¹³⁸ enacting a substantial socioeconomic burden on individuals and communities.¹³⁹ An estimated

¹²⁸ As above, 2057

¹²⁹ As above 2056

¹³⁰ As above, 2052

¹³¹ M Du and others 'Increasing incidence rates of sexually transmitted infections from 2010 to 2019: An analysis of temporal trends by geographical regions and age groups from the 2019 Global Burden of Disease Study' (2022) 22(574) *BMC Infectious Diseases* 1-16.

¹³² As above, 9.

¹³³ As above, 10.

¹³⁴ H Wand and others 'Estimating prevalence and incidence of sexually transmitted infections among South African women: Implications of combined impacts of risk factors' (2020) 31(11) *International Journal of STD and AIDS*. 1093-1101.

¹³⁵ As above, 1098.

¹³⁶ WHO 'Factsheet: Human Papilloma Virus and Cancer' 5 March 2024, <https://www.who.int/news-room/factsheets/detail/human-papilloma-virus-and-cancer> (accessed 25 March 2024).

¹³⁷ WHO 'Factsheet: Sexually transmitted infections' 10 July 2023, [https://www.who.int/news-room/factsheets/detail/sexually-transmitted-infections-\(stis\)](https://www.who.int/news-room/factsheets/detail/sexually-transmitted-infections-(stis)) (accessed 25 March 2024).

¹³⁸ M Yazdkhasti and others 'Unintended pregnancy and its adverse social and economic consequences on health system: A narrative review article' (2015) 44 *Iran Journal of Public Health* 12-21.

¹³⁹ As above, 13.

121 million unintended pregnancies occurred between 2015 and 2019 globally.¹⁴⁰ Of these, 61 per cent result in abortion.¹⁴¹ Unintended pregnancies can lead to adverse health outcomes for women and girls, such as maternal mortality and morbidity.¹⁴²

Various factors lead to unintended pregnancies. These include the unavailability of sexual and reproductive healthcare and information, lack of suitable contraceptive options for women's specific bodies and circumstances, harmful societal norms and stigma surrounding women's control over their fertility and bodies, incidents of sexual violence and reproductive coercion, negative attitudes or shaming in healthcare services, poverty, and hindered economic development, as well as gender inequality.¹⁴³ A study in Ethiopia found that 65.6 per cent of women with disabilities had experienced unintended pregnancies in a sample of 355.¹⁴⁴

Family planning is a crucial measure for assessing the extent of universal reproductive health coverage.¹⁴⁵ Unmet need for family planning refers to sexually active women of reproductive age who don't want more children or want to delay the next child but are not using contraception.¹⁴⁶ The use of contraception prevented over 141 million unintended pregnancies, 29 million unsafe abortions, and 150,000 maternal deaths globally in 2022.¹⁴⁷ In LMICs, it is estimated that around 222 million women have a need for contraception that is not being met.¹⁴⁸ Unmet family planning needs are more pronounced among women with disabilities compared to their counterparts without disabilities.¹⁴⁹ The Causal Framework reasons for the unmet need for family planning include 1) weak, inconsistent or ambivalent fertility preferences; 2) generic disapproval of preventing pregnancy; 3) method-specific barriers to use; 4) perceived low risk of getting pregnant; and 5) partner-related factors.¹⁵⁰

¹⁴⁰ Guttmacher Institute 'Factsheet: Unintended pregnancy and abortion worldwide' March 2022, <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide> (accessed 19 May 2024)

¹⁴¹ As above.

¹⁴² B Bottcher and others 'Causes and consequences of unintended pregnancies in the Gaza Strip: A qualitative study' (2018) 45 *BMJ* 159-163.

¹⁴³ UNFPA 'Nearly half of all pregnancies are unintended—a global crisis, says new UNFPA report' March 2022, <https://www.unfpa.org/press/nearly-half-all-pregnancies-are-unintended-global-crisis-says-new-unfpa-report> (accessed 21 March 2024).

¹⁴⁴ Z Tenaw and others 'Unintended pregnancy and its associated factors among women with disabilities in central Sidama National Regional State, Ethiopia: A multilevel analysis' (2023) 23(522) *BMC Public Health* 1-11.

¹⁴⁵ AA Gelagay and others 'Magnitude of unmet need for family planning and associated factors among women in the extended postpartum period in Dabat district, Northwest Ethiopia: Evidence from Dabat demographic health surveys' (2023) 23 *BMC Public Health* 1-7.

¹⁴⁶ SE Bradley & JB Casterline 'Understanding unmet need: History, theory, and measurement' (2015) 45(2) *Stud Family Planning* 123-150.

¹⁴⁷ J Coulson and others 'Understanding the global dynamics of continuing unmet need for family planning and unintended pregnancy' (2023) 7 (1) *China Population Development Studies* 1-14.

¹⁴⁸ K Machiyama and others 'Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: Protocol or a multi-site cohort study. (2017) 14 (23) *Reproductive Health* 1-11.

¹⁴⁹ S Marks and others 'Improving access to family planning for women with disabilities in Kaduna city, Nigeria: Study protocol for a pragmatic cluster-randomised controlled trial with integrated process evaluation' (2024) 25(1) *Trials* 1-15.

¹⁵⁰ Marks and others (n 149) 4.

Adolescent pregnancy/Child marriage

Power-gender relationships, limited SRH knowledge, lack of access to SRH services, early marriage, and unmet need for contraception contribute to adolescent pregnancy.¹⁵¹ Adolescent pregnancy, which refers to pregnancy in females aged between 10-19 years, is a widespread phenomenon globally.¹⁵² Early childbearing has far-reaching health, social, and economic challenges.¹⁵³ SSA has an adolescent birth rate of 100.5 births per 1000 girls aged 15-19 years, twice the global average.¹⁵⁴ The adolescent birth rate in South Africa is 41 births per 1000 girls aged 15-19 years¹⁵⁵

Child marriage is one of the driving factors that leads to adolescent pregnancy and early childbearing.¹⁵⁶ Every year, around 15 million girls under the age of 18 are forced into marriage globally.¹⁵⁷ Child marriage is an SRHR issue.¹⁵⁸ Females who get married before they turn 18 generally have limited authority over their reproductive autonomy, limited access to contraception, increased risk of STIs and unwanted pregnancies.¹⁵⁹ The SRH challenges faced by adolescent girls living with disabilities increase their likelihood of early childbearing and motherhood.¹⁶⁰ A 2016 study using demographic and health survey data in Uganda found that women with disabilities have higher rates of early childbearing.¹⁶¹

Maternal mortality/Unsafe abortions

Maternal mortality is a result of discrimination against women and the denial of SRHR.¹⁶² International and regional human rights treaties concede that maternal mortality is a human

¹⁵¹ UNFPA 'Report on the regional forum on adolescent pregnancy, child marriage, and early union' 2018, <https://www.unicef.org/eap/reports/report-regional-forum-adolescent-pregnancy-child-marriage-and-early-union-se-asia> (accessed 21 March 2024).

¹⁵² AI Ajayi and others 'Lived experiences of pregnant and parenting adolescents in Africa: A scoping review' (2023) 20 *Reproductive Health* 1-13.

¹⁵³ M Mangeli and others 'Exploring the challenges of adolescent mothers from their life experiences in the transition to motherhood: A qualitative study' (2017) 11(23) *Journal of Family and Reproductive Health* 165.

¹⁵⁴ L Carvajal and others 'Basic maternal healthcare coverage among adolescents in 22 Sub-Saharan African countries with high adolescent birth rates' (2020) 10(2) *Journal of Global Health* 1-10.

¹⁵⁵ P Barron and others 'Teenage births and pregnancies in South Africa, 2017-2021 – a reflection of a troubled country: Analysis of public sector data' (2022) 112(4) *South African Medical Journal* 252-258.

¹⁵⁶ UNFPA 'Why addressing child marriage and adolescent pregnancy is essential' 2017, <https://wcaro.unfpa.org/sites/default/files/pub-pdf/UNFPA-WCARO-CHILD-MARRIAGE-POSITION-PAPER-WEB.pdf> (accessed 21 March 2024).

¹⁵⁷ A Pourtaheri and others 'Prevalence and factors associated with child marriage, a systematic review' (2023) 23(531) *BMC Women's Health* 1-9.

¹⁵⁸ As above, 2.

¹⁵⁹ As above, 3.

¹⁶⁰ B Kwagala & SO Wandera 'The determinants of early childbearing by disability status in Uganda: An analysis of demographic and health survey data' (2021) 14(40) *Pan African Medical Journal* 1-11.

¹⁶¹ As above, 1.

¹⁶² United Nations Office of the High Commissioner 'Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance' 2012, <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/TGReduceMaternalMortality.pdf> (accessed 21 March 2024).

rights violation. It is well established that maternal mortality infringes on the following human rights: the right to life and survival, the right to health and reproductive care, the right to dignity, the right to be free from torture and inhuman and degrading treatment, the right to liberty, the right to non-discrimination, and the right to information.

It is estimated that worldwide, there are about 223 maternal deaths per 100,000 live births annually.¹⁶³ The maternal mortality in Nigeria, South Sudan and Chad exceeded 1000 maternal deaths per 100,000 live births in 2020.¹⁶⁴ Women with disabilities have a higher risk for obstetric complications.¹⁶⁵ According to the Healthcare Cost and Utilization Project Nationwide Inpatient Sample data from 2004-2017 in the United States, maternal mortality in women with intellectual and developmental disabilities was found to be 284 per 100,000 deliveries.¹⁶⁶ This is almost four times higher than the rate seen in women without intellectual and developmental disabilities, which was 69 per 100,000 deliveries. A Canadian study found that women with disabilities face higher maternal mortality and morbidity risks.¹⁶⁷

The Status of Women's Health in South Africa Report 2022 revealed that the facility maternal mortality ratio (MMR) declined from 105.7 to 88.0 per 100,000 live births in 2018 and 2020.¹⁶⁸ Although the findings demonstrate a decline in the MMR, avoidable maternal deaths still occur in South Africa. Factors linked to maternal mortality include poverty, inadequate nutrition, GBV, gender inequality, HIV/AIDS, tuberculosis, substandard reproductive healthcare and coverage, lack of antenatal care, the critical shortage of HCPs, dysfunctional comprehensive emergency obstetric services, ill-equipped healthcare facilities, poor interfacility transport, poor clinical assessments, delays in referral, and disparities in maternal and child health service coverage.¹⁶⁹

¹⁶³ A Khalil and others 'A call to action: The global failure to effectively tackle maternal mortality rates' (2023) 11 *Lancet* 1165-1167.

¹⁶⁴ As above, 1165.

¹⁶⁵ C Signore and others 'The Intersection of disability and pregnancy: Risks for maternal morbidity and mortality' (2021) 30(2) *Journal of Women's Health* 147-153.

¹⁶⁶ M Mitra 'Severe maternal morbidity and maternal mortality in women with intellectual and developmental disabilities' (2021) 61(6) *American Journal of Preventative Medicine* 872-881.

¹⁶⁷ HK Brown and others 'Association of preexisting disability with severe maternal morbidity or mortality in Ontario, Canada' (2021) 4(2) *Jama Network Open* 1-14.

¹⁶⁸ Statistics South Africa 'Status of Women's Health in South Africa Report' 2022, <https://www.statssa.gov.za/publications/03-00-18/03-00-182022.pdf> (accessed 21 March 2024).

¹⁶⁹ RMM Mmusi-Phetoe 'Social factors determining maternal and neonatal mortality in South Africa: A qualitative study' (2016) 39(1) *Curationis* 1-8; NJ Bomela 'Maternal mortality by socio-demographic characteristics and cause of death in South Africa: 2007-2015' (2020) 20(157) *BMC Public Health* 1-20; B Tlou 'Underlying determinants of maternal mortality in a rural South African population with high HIV prevalence (2000-2014): A population-based cohort analysis' (2018) 13(9) *PLOS One* 1-8; MHL Mabaso and others 'Overview of maternal, neonatal and child deaths in South Africa: Challenges, opportunities, progress and future prospects' (2014) (2) *International Journal of MCH and AIDS* 182-189.

According to the WHO, 4.7 per cent to 13.2 per cent of all maternal deaths are caused by unsafe abortions.¹⁷⁰ Additionally, 45 per cent of all induced abortions are considered unsafe globally.¹⁷¹ An estimated 6.2 million unsafe abortions occur annually in SSA.¹⁷² Although South Africa has laws legally permitting the termination of pregnancies, half of all abortions occur outside designated health facilities.¹⁷³ Factors contributing to unsafe abortion include conscientious objection to abortion by HCPs, discrimination, stigma and health system deficiencies.¹⁷⁴ Despite the importance of data on the prevalence of unsafe abortions among women with disabilities, there remains a paucity of this data. However, women with disabilities face barriers to accessing SRH services, including safe abortion.¹⁷⁵

Forced/coerced/involuntary sterilisation

Marginalised women, which includes those with mental and physical disabilities, racial minorities, poor socioeconomic status, and living with HIV and other illnesses like epilepsy, have been subjected to forced and coerced sterilisation throughout history.

In 2017, Catalina Devandas Aguilar, the UN Special Rapporteur on the Rights of Persons with Disabilities at that time, pointed out that:

Girls and young women with disabilities are often coerced to terminate their pregnancies due to negative stereotypes about their ability to parent and eugenics-based fears of having a child with disabilities.¹⁷⁶

Involuntary sterilisation is a double jeopardy of violence and discrimination against women.¹⁷⁷ Sterilisation rates for women and girls with disabilities are up to three times higher than their counterparts without disabilities.¹⁷⁸ Ableism and eugenics have been the driving forces behind forced and non-consensual sterilisation.¹⁷⁹ The concept of ableism pertains specifically to the social structures, perceived supremacy and attitudes that reduce the bodies and quality of life

¹⁷⁰ WHO 'Abortion' 25 November 2021, <https://www.who.int/news-room/fact-sheets/detail/abortion> (accessed 21 March 2024).

¹⁷¹ As above.

¹⁷² Guttmacher Institute 'Factsheet: Abortion in Sub-Saharan Africa' December 2020, <https://www.guttmacher.org/factsheet/abortion-sub-Saharan-africa> (accessed 21 March 2024).

¹⁷³ HEARD 'Unsafe abortion in South Africa: Country factsheet' May 2016, <https://www.heard.org.za/publications-post/unsafe-abortion-in-south-africa-country-factsheet/> (accessed 21 March 2024).

¹⁷⁴ Amnesty International 'South Africa: Women and girls risk unsafe abortions after being denied legal abortions' 31 January 2017, <https://www.amnesty.org/en/latest/press-release/2017/01/south-africa-women-and-girls-risk-unsafe-abortions-after-being-denied-legal-services/> (accessed 17 June 2024).

¹⁷⁵ J Fletcher and others 'Centering disability visibility in reproductive healthcare: Dismantling barriers to achieve reproductive equity' (2023) 19 *Women's Health* 1-10.

¹⁷⁶ United Nations General Assembly 'Report of the Special Rapporteur on the rights of persons with disabilities A/72/133' 14 July 2017, https://www.ohchr.org/Documents/Issues/Disability/A_72_133_EN.docx (accessed 21 March 2024).

¹⁷⁷ E Durojaye 'Involuntary sterilisation as a form of violence against women in Africa' (2017) 53(5) *Journal of Asian and African Studies* 721-731.

¹⁷⁸ Guttmacher Institute (n 140) 11.

¹⁷⁹ Fletcher and others (n 175) 3.

of persons with disabilities.¹⁸⁰ The involuntary sterilisation of young girls and women with mental disabilities was also rationalised by the myth that mental defects were inherited.¹⁸¹ Furthermore, the SRH of women with disabilities is limited due to the harmful beliefs that they are asexual and incapable of mothering.¹⁸² Stereotypes and myths regarding disability are not grounds to justify or legitimise involuntary sterilisation.¹⁸³

Gender-based violence

GBV is a severe SRHR issue, defined by the UN as:

Any act that is based on gender and results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women. This includes threats of such acts, coercion, or arbitrary deprivation of liberty, whether in public or private life.¹⁸⁴

According to global statistics, 30 per cent of women experience physical and/or sexual violence from their partner or a non-partner in their lifetime.¹⁸⁵ Factors include patriarchal structures, harmful social norms, gender inequality, limitations on women's autonomy, and lower negotiating skills among girls and women.¹⁸⁶ GBV causes severe physical harm, such as head and spinal injuries, loss of hearing, vision loss and even miscarriage. In addition to that, it also has severe psychological impacts that include post-traumatic stress disorder, depression, and anxiety. Furthermore, it causes behavioural changes such as suicidal ideation, alcohol abuse, lack of confidence and constant fear of living. GBV has a devastating impact on the health and wellbeing of women.¹⁸⁷ Intimate Partner Violence (IPV) can negatively impact SRH, leading to unintended pregnancies, unsafe abortions, STIs, HIV, pelvic inflammatory disease, urinary tract infections and sexual dysfunction.¹⁸⁸ Hence, SRHR is infringed on by GBV and IPV.

¹⁸⁰ As above, 4.

¹⁸¹ E Tilley and others 'The silence is roaring: Sterilisation, reproductive rights and women with intellectual disabilities' (2012) 27(3) *Disability and Society* 413-426.

¹⁸² As above, 41.

¹⁸³ W Holness 'Informed consent for sterilisation of women and girls with disabilities in the light of the Convention on the Rights of Persons with Disabilities' (2013) 27(4) *Gender and Human Rights: Biology and Bodies* 35-54.

¹⁸⁴ UN General Assembly 'Declaration on the elimination of violence against women A/RES/48/104' 20 December 1993, <https://www.refworld.org/docid/3b00f25d2c.html> (accessed 24 March 2024).

¹⁸⁵ WHO 'Factsheet: Violence against women' 25 March 2024, <https://www.who.int/news-room/fact-sheets/detail/violence-against-women> (accessed 24 April 2024).

¹⁸⁶ P Bhattacharjee and others 'Prevalence and patterns of gender-based violence across adolescent girls and young women in Mombasa, Kenya' (2020) 20(229) *BMC Women's Health* 1-8.

¹⁸⁷ Centre for the Study of Violence and Reconciliation 'Gender-based violence (GBV) in South Africa: A brief review' April 2016, <https://www.csvr.org.za/pdf/Gender%20Based%20Violence%20in%20South%20Africa%20-%20A%20Brief%20Review.pdf> (accessed 1 April 2024).

¹⁸⁸ WHO 'Factsheet: Understanding and addressing violence against women' 29 November 2012, <https://www.who.int/publications/i/item/WHO-RHR-12.35> (accessed 20 April 2024).

An upward trend in the prevalence of GBV has been recognised in South Africa.¹⁸⁹ During 2019 and 2020, sexual offences increased by 146 incidents a day.¹⁹⁰ South Africa's Minister of Police, Bheki Cele, reported 10,519 rape cases, 1,514 attempted murders, and 14,401 assault cases against women between July and September 2023.¹⁹¹ Persons with disabilities have a 1.5 times higher risk of violence than those without disabilities,¹⁹² and women with disabilities are more likely to experience violence compared to men with disabilities.¹⁹³ Furthermore, individuals with intellectual and psychosocial disabilities are at a greater risk of experiencing violence.¹⁹⁴ Women with disabilities are at four times higher risk of experiencing IPV compared to women without disabilities.¹⁹⁵ GBV against persons with disabilities can include forced sterilisation, abortion, emotional abuse related to their disability, denial of sexual rights, sexual violence, physical violence, denial of basic needs, and denial of assistance and devices.¹⁹⁶ The discrimination faced by girls and women is greater than their male counterparts.¹⁹⁷ It has been reported that in some cases, female infants who have disabilities are at risk of being subjected to 'mercy killings'.¹⁹⁸

Research conducted by Hanass-Hancock and others revealed that women with disabilities in South Africa are subjected to both IPV and non-partner violence.¹⁹⁹ The survivors with disabilities in the study reported that they were discouraged from disclosing incidents of sexual and physical assault.²⁰⁰ Furthermore, survivors with disabilities indicated a lack of support from their social networks and the justice system.²⁰¹ Notably, family members were often identified as perpetrators of the sexual and physical violence.²⁰² A woman with an

¹⁸⁹ V O'Regan 'Unacceptable' spike in gender-based violence and femicide as lawlessness continues to grip South Africa' *Daily Maverick* 23 November 2022, <https://www.dailymaverick.co.za/article/2022-11-23-unacceptable-spike-in-gender-based-violence-and-femicide-as-lawlessness-continues-to-grip-south-africa/> (accessed 21 April 2024).

¹⁹⁰ African Health Organisation 'Gender Based Violence Fact Sheet' 14 January 2021, <https://aho.org/fact-sheets/gender-based-violence-fact-sheet/> (accessed 22 May 2024)

¹⁹¹ A Mpako & S Ndoma 'South Africans see gender-based violence as most important women rights issue to address' (2023) 738 *Afrobarometer* 1-10.

¹⁹² WHO (n 1).

¹⁹³ Mpako & Ndoma (n 191) 2.

¹⁹⁴ M Starke and others 'People with intellectual disability and their risk of exposure to violence: Identification and prevention – a literature review' (2024) *Journal of Intellectual Disabilities* 1-24.

¹⁹⁵ UNFPA 'Disability inclusion in gender-based violence programming' July 2023, https://asiapacific.unfpa.org/sites/default/files/pub_pdf/unfpa_gbv_and_disability_inclusion_final_august_11.pdf (accessed 21 March 2024).

¹⁹⁶ As above, 2.

¹⁹⁷ As above, 6.

¹⁹⁸ G Berger and others 'Sexual and Reproductive Health and Rights for All: Disability Inclusion from Theory to Practice' 2022, https://www.hi-us.org/sn_uploads/document/1288_HI_Guidelines_17_10_22_DIGITAL.pdf (accessed 22 May 2024)

¹⁹⁹ J Hanass-Hancock and others 'Access to sexual and reproductive health and rights services for young women with and without disabilities during a pandemic' (2024) 4 *Disabilities* 972-995

²⁰⁰ As above, 986

²⁰¹ As above

²⁰² As above

intellectual disability, who survived a traumatic experience, reported that she was sexually assaulted by her cousin during the COVID-19 lockdown period.²⁰³

Some survivors with disabilities noted that healthcare facilities failed to provide GBV services and counselling.²⁰⁴ Those with hearing impairments faced challenges in accessing healthcare services due to communication barriers and the lack of sign language interpretation.²⁰⁵ The researchers also noted that survivors of IPV and GBV experienced unplanned pregnancies and infection with HIV.²⁰⁶ The findings of Hanass-Hancock and others corroborate global research suggesting that women with disabilities have a higher risk of IPV compared to their counterparts without disabilities.²⁰⁷

1.8.2 Factors influencing access to SRH services

The Socio-Ecological Model (SEM) is a useful tool that allows for nuanced analysis of an issue like access to SRH services due to the way it delves into the intricate dynamics between individual, relationship, community, and societal elements.²⁰⁸ Originally conceptualised by Urie Bronfenbrenner in the 1970s to describe human development, the model was formalised as a theory in the 1980s.²⁰⁹ SEM suggests that health is affected by factors at different levels, including individual, interpersonal, organisational, community, and public policy (Figure 1). This model will be used to examine the factors that impact access to SRH services.

²⁰³ As above

²⁰⁴ As above

²⁰⁵ As above

²⁰⁶ As above

²⁰⁷ As above, 990

²⁰⁸ JF Kilanowski 'Breadth of the socio-ecological model' (2017) 22(4) *Journal of Agromedicine* 295-297.

²⁰⁹ As above, 297.

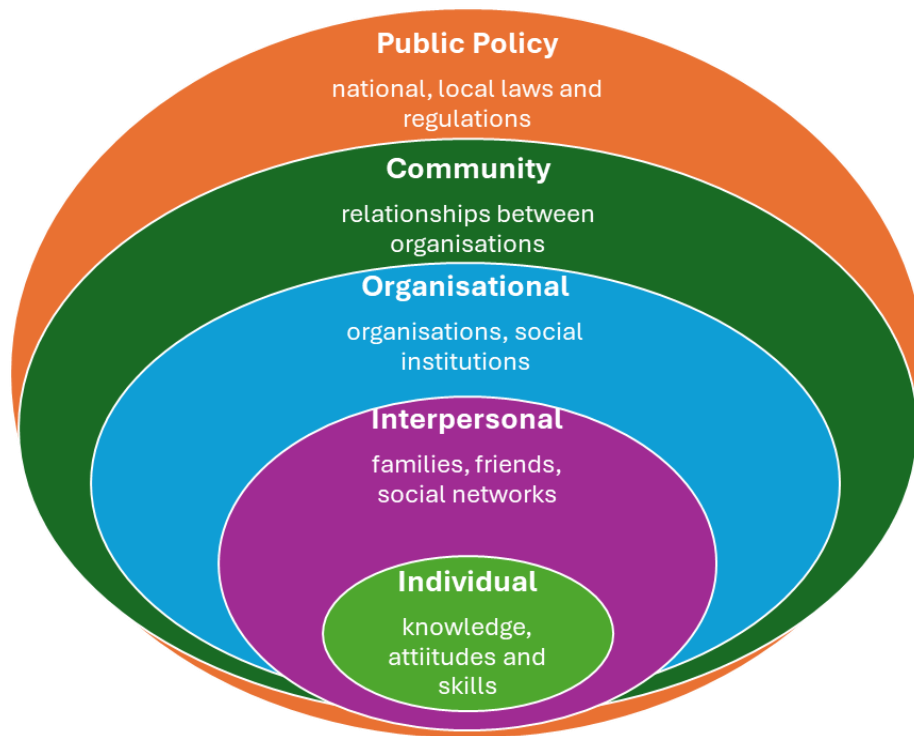


Figure 1: The Socio-Ecological Model²¹⁰

Individual level

Individual attitudes, knowledge, attitudes, and skills can influence access to SRH services. Baigry and others found that young people were not accessing SRH services due to their lack of knowledge about the services,²¹¹ including thinking that they were too young to access them.²¹² According to a study conducted in Nigeria, many adolescents are not aware of how to obtain contraceptives.²¹³ Hailemariam and others reported that Ethiopian adolescents were unsure which health facilities provided SRH services.²¹⁴ Low self-esteem and lack of confidence can prevent adolescents from accessing and utilising SRH services.²¹⁵ The fear of being identified in healthcare settings and the stigma surrounding sexuality pose additional barriers to accessing SRH services.²¹⁶

²¹⁰ BC Lee and others 'Using the socio-ecological model to frame agricultural safety and health interventions' (2017) 22(4) *Journal of Agromedicine* 298-3.

²¹¹ MI Baigry and others 'Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island Countries and Territories: A scoping review' (2023) 18(1) *PLOS One* 1-13.

²¹² As above, 6.

²¹³ U Ezenwaka and others 'Exploring factors constraining utilisation of contraceptive services among adolescents in Southeast Nigeria: An application of the socio-ecological model' (2020) 20(1162) *BMC Public Health* 1-11.

²¹⁴ S Hailemariam and others 'Challenges faced by female out of school adolescents in accessing and utilising sexual and reproductive health service: Qualitative exploratory study in Southwest, Ethiopia' (2021) 12 *Journal of Primary Care and Community Health* 1-8.

²¹⁵ Rade and others (n 97) 7.

²¹⁶ Hailemariam and others (n 214) 6.

A systematic review of 26 studies found that barriers faced by persons with disabilities when accessing SRH services include their refugee status, low literacy levels, lack of knowledge and understanding of SRH, and limited self-efficacy.²¹⁷ Esmail and others found that persons with disabilities received inadequate sex education, resulting in a limited understanding of sexuality.²¹⁸ A person's autonomy can influence access to SRH services and making decisions about their sexual life and use of contraception.²¹⁹

Interpersonal level

The interpersonal factors affecting access to and utilisation of SRH services include formal and informal social networks, and social support systems such as family, peer pressure, and partner relationships. Inadequate communication between parents and their children regarding SRH issues can hinder adolescents' ability to access SRH services and information.²²⁰ In addition, negative attitudes of parents towards sex education and contraceptive information create additional barriers for adolescents to access SRH services.²²¹

A study conducted in Ghana found that persons with disabilities encountered insufficient support and even discrimination from their family members when seeking to access SRH services.²²² Similarly, only 9 per cent of 549 persons with disabilities in Ethiopia reported receiving support from family members regarding their SRH needs.²²³ A systematic review revealed that parents discouraged their children with disabilities from engaging in sexual activity primarily due to fear of pregnancy.²²⁴ Hence, persons with disabilities are not able to have transparent communication with their parents about SRH issues.

Institutional/organisational level

At the institutional level, facility-related and provider-related factors can hinder or facilitate access to SRH services.²²⁵ The facility-related barriers to accessing healthcare facilities may

²¹⁷ JK Ganle and others 'Barriers facing persons with disability in accessing sexual and reproductive health services in Sub-Saharan Africa: A systematic review (2020) 15 (10) *PLOS One* 1-19.

²¹⁸ Esmail and others (n 25) 1149.

²¹⁹ Ezenwaka and others (n 213) 7.

²²⁰ As above, 5.

²²¹ As above, 6.

²²² A Seidu and others 'God is my only health insurance: A mixed-methods study on the experiences of persons with disability in accessing sexual and reproductive health services in Ghana' (2023) 11 *Frontiers in Public Health* 1-18.

²²³ Rade and others (n 97) 11.

²²⁴ NB Sidamo and others 'Socio-ecological analysis of barriers to access and utilization of adolescent sexual and reproductive health services in Sub-Saharan Africa: A qualitative systematic review' (2023) 14 *Journal of Contraception* 103-118.

²²⁵ As above, 108.

include an unhelpful environment, shortages of medicines and supplies, and inaccessibility of services.²²⁶ Some barriers that restrict access to SRH services include HCPs' behaviour, competency, and attitudes.²²⁷ Persons with disabilities in Ghana reported that health infrastructure is disability unfriendly.²²⁸ Navigating the health facilities in the Ghanaian study was extremely difficult for persons with visual and physical impairments.²²⁹

According to studies in Nigeria and Zambia, adolescents seeking access to SRH services encountered rude HCPs.²³⁰ Adolescents reported that HCPs tend to be judgmental and often rebuke them.²³¹ In an Ethiopian study, adolescents reported that HCPs refused to give them contraceptives, claiming they were too young to be sexually active. Similarly, persons with disabilities encounter discriminative behaviours from HCPs. Persons with disabilities in Ghana have reported that some medical professionals ridicule their disabilities and ability to engage in sexual activity. This resonates with the harmful perceptions that persons with disabilities are asexual.²³² Long waiting times and lack of privacy are barriers to accessing SRH services.²³³

Women with hearing impairments in South Africa have reported that HCPs lack proficiency in sign language, and there is an absence of interpreters.²³⁴ Consequently, these individuals can only access SRH services with the assistance of family members.²³⁵ Given these circumstances, women with hearing impairments faced challenges in accessing confidential healthcare services.²³⁶ Communication barriers result in insufficient information, which adversely affects autonomy and informed decision-making.²³⁷

Community level

Stigma, community attitudes, and religious, social, and gender norms influence access to SRH services at the community level. A study in rural KwaZulu Natal, South Africa, found that many young people perceived negative attitudes from the community when seeking SRH

²²⁶ As above, 109.

²²⁷ As above.

²²⁸ Seidu and others (n 222) 8.

²²⁹ As above, 10.

²³⁰ AG Onokerhoraye & JE Dudu 'Perception of adolescents on the attitudes of providers on their access and use of reproductive health services in Delta State, Nigeria' (2017) 9(1) *Health* 88; A Silumbwe and others 'Community and health systems barriers and enablers to family planning and contraceptive services provision and use in Kabwe District, Zambia' (2018) 18(1) *BMC Health Service Research* 1–11.

²³¹ Sidamo and others (n 224) 111.

²³² Seidu and others (n 222) 12.

²³³ As above, 11.

²³⁴ Hanass-Hancock and others (n 199) 989

²³⁵ As above

²³⁶ As above

²³⁷ As above

services.²³⁸ They felt stigmatised for seeking SRH services due to community gossip and perceptions of promiscuity.²³⁹ Similarly, Sidamo and others found in a systematic review that young unmarried women accessing SRH services in SSA were often accused of prostitution by their communities who believed SRH services were for married women.²⁴⁰ The unacceptability of contraception use in certain religions deters access to family planning services in Nigeria and Ethiopia.²⁴¹

Cultural norms that discourage the use of contraception are imposed on adolescent girls and young women.²⁴² In some Nigerian communities, there is cultural opposition to the use of contraception by women to prevent pregnancy.²⁴³ In patriarchal societies, the sexuality of young women is often controlled, including limiting their access to SRH services.²⁴⁴

Persons with disabilities in Uganda face discrimination and societal exclusion, including being perceived as asexual and not needing SRH services.²⁴⁵ Children with disabilities are often excluded from sex education in Ugandan communities.²⁴⁶ In Ghana, persons with disabilities reported that some religious beliefs consider the use of contraception as sinful, equating it to abortion.²⁴⁷ Negative community perceptions of sexuality and disability hinder access to SRH services.²⁴⁸

Public policy level

International and regional human rights law and consensus documents often guide national law and policies in implementing SRHR programmes and services. National laws and policies can facilitate or hinder access to SRH services.²⁴⁹ The barriers imposed by national laws and policies include third-party authorisation to SRH services, criminalisation of same-sex sexual conduct, sex work and abortion.²⁵⁰ National laws and policies restricting bodily autonomy undermine SRHR. Third-party authorisation affects girls and women where they may be forced

²³⁸ N Ngwenya and others 'Behavioural and socio-ecological factors that influence access and utilisation of health services by young people living in rural KwaZulu-Natal, South Africa: Implications for intervention' (2020) 15(4) *PLOS One* 1-15.

²³⁹ As above, 10.

²⁴⁰ Sidamo and others (n 224) 112.

²⁴¹ As above, 113.

²⁴² Ezenwaka and others (n 213) 5.

²⁴³ As above, 6.

²⁴⁴ As above, 5.

²⁴⁵ SE Ahumuza and others 'Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda' (2014) 11(59) *Reproductive Health* 1-9.

²⁴⁶ As above, 2.

²⁴⁷ Seidu and others (n 222) 9.

²⁴⁸ As above, 10.

²⁴⁹ L Ferguson and others 'Why a good law is not always good enough: A global review of restrictions to supportive laws for sexual and reproductive health and rights' (2024) 9 *BMJ Glob Health* 1-10.

²⁵⁰ As above, 4.

to seek permission from parents or spouses to access SRH services.²⁵¹ China's one-child policy, enacted in 1980 and officially discontinued in 2016, is an example of a draconian domestic policy controlling reproduction and population growth.²⁵² The criminalisation of abortion also drives unsafe abortion and maternal mortality.²⁵³

Ganle and others noted that unfriendly legal environments and policies towards SRH impact persons with disabilities.²⁵⁴ The exclusion of persons with disabilities from SRH policy and programmes impedes access to SRH services. Disability inclusion in SRH policy and programmes is critical to the SDGs and, ultimately, 'Health for All'.²⁵⁵

1.8.3 Understanding disability

International classification of disability

The WHO states that disability is not solely a result of biological or social factors but rather a complex interaction between health conditions, personal factors, and the environment, as depicted in Figure 2.²⁵⁶ The International Classification of Functioning, Disability and Health (ICF) framework was developed by the WHO in 2001 and provides a universal language for understanding disability and its various challenges.²⁵⁷ The relationship between body functions and structures, activities and participation, and the environment is examined,²⁵⁸ and the medical, social, individual, and environmental influences are considered, providing a biopsychosocial approach to health and disability.²⁵⁹ Persons with disabilities may have physical, mental, sensory and intellectual impairments.²⁶⁰

²⁵¹ Starr and others (n 22) 2650.

²⁵² As above, 2651.

²⁵³ F de Londras and others 'The impact of criminalisation on abortion-related outcomes: A synthesis of legal and health evidence' (2022) 7(12) *BMJ Global Health*. 1-13.

²⁵⁴ Ganle and others (n 217) 12.

²⁵⁵ WHO 'Factsheet: Disability' 7 March 2023, <https://www.who.int/news-room/fact-sheets/detail/disability-and-health> (accessed 29 April 2024).

²⁵⁶ WHO 'International Classification of Disability and Health' 2, 2001, <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health> (accessed 21 March 2024).

²⁵⁷ M Hader-Frumer and others 'The international classification of functioning, disability and health: Accuracy in aquatic activities reports among children with developmental delay' (2023) 10 *Children* 1-18.

²⁵⁸ N Kostanjsek and others 'Use of the international classification of functioning, disability and health (ICF) as a conceptual framework and common language for disability statistics and health information systems' (2011) *BMC Public Health* 1-11.

²⁵⁹ As above, 3.

²⁶⁰ Art 1, CRPD.

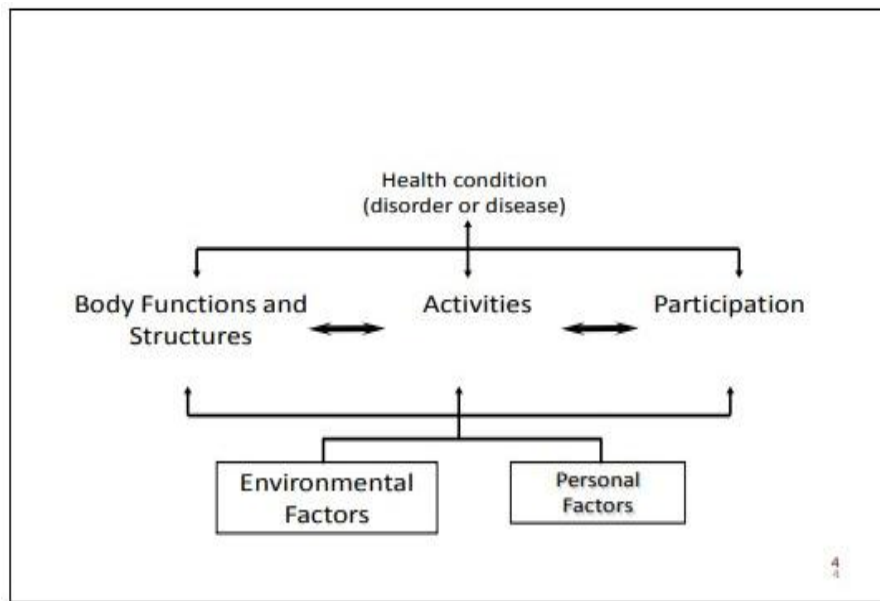


Figure 2: The components of disability²⁶¹

Models of disability

Various models of disabilities exist, including the moral model (disability as an act of God), medical model (disability as a disease), social model (disability as a socially constructed phenomenon), identity model (disability as an identity), human rights model (disability as a human rights issue), cultural model (disability as culture), economic model (disability as a challenge to productivity), charity model (disability as victimhood) and limit model (disability as embodied experience).²⁶² For this research, the medical model, social model, and human rights model approaches to disability are discussed.

Psychologist Thomas Szasz developed the medical model of disability, also known as the biomedical model, in the 1950s.²⁶³ The model reduces disability to a medical problem, and has been criticised for attempting to cure disability, which can lead to the stigmatisation of human differences.²⁶⁴ Bunbury asserts that the medical model implies that persons with disabilities are responsible for their condition.²⁶⁵ The medical model creates unequal power

²⁶¹ WHO (n 238).

²⁶² M Retief & R Letšosa 'Models of disability: A brief overview' (2018) 74(1) *HTS Teologiese Studies/ Theological Studies* 1-8.

²⁶³ AJ Hogan 'Social and medical models of disability and mental health' (2019) 191(1) *Humanities, Medicine and Society* 16-18.

²⁶⁴ Z Zaks 'Changing the medical model of disability to the normalisation model of disability: Clarifying the past to create a new future direction' (2023) *Disability and Society* 1-28.

²⁶⁵ S Bunbury 'Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination' (2019) 19(1) *International Journal of Discrimination and the Law* 26-47.

dynamics with medical professionals and perpetuates feelings of inferiority, oppressing persons with disabilities.²⁶⁶ Of particular concern is that persons with disabilities often feel excluded and undervalued due to the medical model's approach, which pressures them to conform to a predetermined norm.²⁶⁷ The medical model led to offensive language, using terms like invalid, handicap, crippled, and retarded.²⁶⁸ The negative view of disability and the desire to 'normalise' humans as a result of the medical model, may be linked to the forced sterilisation and even euthanasia of persons with disabilities.²⁶⁹ The medical model does not consider the impact of the social environment on disability.²⁷⁰

The social model approach to disability emerged from the activism of the British disability movement.²⁷¹ Recognition of factors in social and physical environments that oppress persons with disabilities is a cornerstone of this model.²⁷² The social model emphasises how impairment and disability interact, and acknowledges the adverse effects of impairment.²⁷³ It advocates for removing social barriers to promote inclusivity for persons with disabilities.²⁷⁴ By focusing on the wider environment, the social model views disability as a social construct,²⁷⁵ perceiving it as a product of oppressive and discriminatory social and institutional contexts imposed on individuals with impairments.²⁷⁶

The human rights-based approach to disability has been influenced by human rights law and policy.²⁷⁷ According to Retief and Letsosa, researchers consider the social and human rights models interchangeable.²⁷⁸ However, there are differences; the social model considers social factors, while the human rights model provides a theoretical framework for disability policy²⁷⁹ and includes civil, political, cultural, social and economic rights.²⁸⁰ Degener argues that the social model of disability focuses solely on explaining the phenomenon of disability,

²⁶⁶ As above, 28.

²⁶⁷ S Goering 'Rethinking disability: The social model of disability and chronic disease' (2015) 8 *Current Review Musculoskeletal* 134-138.

²⁶⁸ As above, 135-136.

²⁶⁹ Retief & Letšosa (n 262) 3.

²⁷⁰ Hogan (n 263) 17.

²⁷¹ Retief & Letšosa (n 262) 4.

²⁷² As above.

²⁷³ Hogan (n 263) 17.

²⁷⁴ Bunbury (n 265) 29.

²⁷⁵ As above, 30.

²⁷⁶ As above.

²⁷⁷ A Lawson & AE Beckett 'The social and human rights models of disability: Towards a complementarity thesis' (2020) 25(2) *International Journal of Human Rights* 348-379.

²⁷⁸ Retief & Letšosa (n 262) 5.

²⁷⁹ As above.

²⁸⁰ As above.

while the human rights model acknowledges the inherent human dignity of persons with disabilities.²⁸¹

The adoption of the CRPD has led to an increased use of the human rights model approach to disability,²⁸² which has been proclaimed as a tool to implement the CRPD.²⁸³ There are eight principles endorsed in Article 3 of the CRPD to guide the human rights model, shown in Figure 3.²⁸⁴ The right to dignity is underscored in healthcare service delivery.

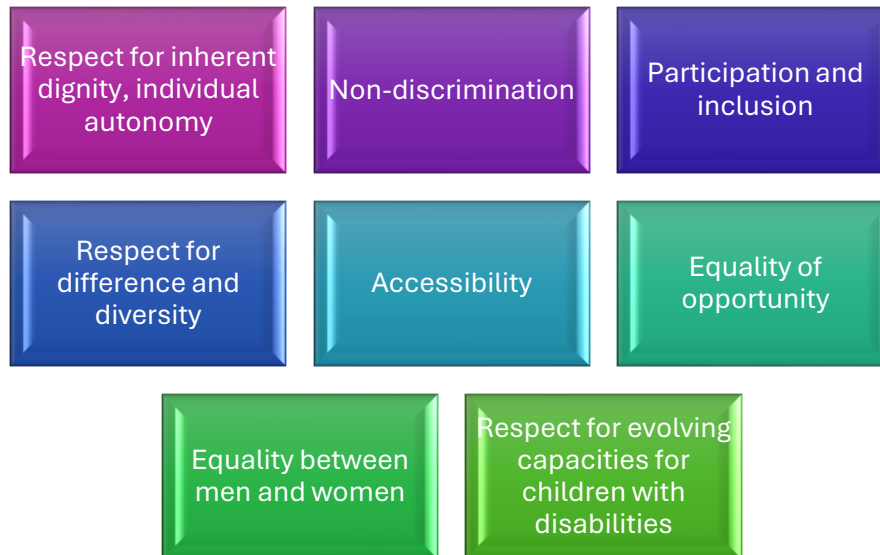


Figure 3: Guiding principles of the human rights model to disability

The human rights based approach establishes the relationship between rights holder and duty bearers.²⁸⁵ States are duty bearers who have obligations to respect, protect and fulfil human rights.²⁸⁶ The social model of disability provides a descriptive approach to disability, while the human rights model prescribes the necessary steps States must take to advance the human rights of persons with disabilities.²⁸⁷ Within the context of SRHR, the duty to respect mandates that States refrain from implementing policies or actions that impede persons with disabilities from enjoying the right to SRH. The duty to protect calls for States to prevent third-party interference with persons with disabilities' ability to access SRH services. Lastly, the duty

²⁸¹ T Deneger 'Human rights model of disability' in P Blanck & E Flynn (eds) *Routledge Handbook on Disability Law and Human Rights* (2017) 31-49.

²⁸² Lawson & Beckett (n 277) 350.

²⁸³ As above.

²⁸⁴ Art 3, CRPD.

²⁸⁵ JK Boesen & T Martin 'Applying a rights-based approach: An inspirational guide for civil society' 2007, <https://www.humanrights.dk/files/media/migrated/applying-a-rights-based-approach-2007-an-inspirational-guide-for-civil-society.pdf> (accessed 16 June 2024).

²⁸⁶ As above, 11.

²⁸⁷ Lawson & Beckett (n 277) 363-364.

to fulfil requires States to take all necessary steps to ensure that persons with disabilities have the support and resources needed to fully exercise their right to SRH.

1.8.4 Interconnections between sexuality, disability and SRHR

The fundamental human right of sexuality plays a crucial role in fostering healthy developmental processes.²⁸⁸ According to Shah, persons with disabilities are also sexual beings; however, they are often denied sexual citizenship.²⁸⁹ Persons with disabilities are often perceived as deviating from societal norms, resulting in their exclusion from the developmental processes that typically equip people for romantic relationships, sexual activity, and reproductive pursuits.²⁹⁰ This societal construct of non-normativity surrounding the physicality of persons with disabilities effectively isolates them from crucial aspects of human experience.²⁹¹ The suppression of persons with disabilities' sexual autonomy contributes to diminished sexual knowledge and education.²⁹²

Studies in South Africa have demonstrated that the sexual lives of persons with disabilities are subject to oppression and stigmatisation.²⁹³ The misconceptions and myths surrounding the sexuality of persons with disabilities is not only prevalent within the broader community but also HCPs.²⁹⁴ In a study by Rohleder and others, persons with disabilities reported that their sexuality was negated through the presumption of asexuality.²⁹⁵ Persons with disabilities also reported that their family members normalised the asexuality narrative by disregarding discussions on sexuality, relationships and marriage.²⁹⁶ The study findings indicated that women with disabilities perceived their physiques as being socially constructed as unappealing, whilst their male counterparts were characterised as lacking virility.²⁹⁷ Males with disabilities were frequently subjected to derision by females regarding their capacity for sexual intercourse, owing to their perceived 'waist down' impairment.²⁹⁸

²⁸⁸ S Shah 'Disabled people are sexual citizens too: Supporting sexual identity, well-being, and safety for disabled young people' (2017) 2 (46) *Frontiers in Education* 1-5

²⁸⁹ As above, 1

²⁹⁰ As above, 2

²⁹¹ R Addlakha and others 'Disability and sexuality: Claiming sexual and reproductive rights' (2017) 25 (50) *Reproductive Health Matters* 4-9

²⁹² Shah (n 288) 2

²⁹³ P Rohleder and others 'Sexuality erased, questioned, and explored: the experiences of South Africans with physical disabilities' (2018) 9 (4) *Psychology and Sexuality* 369-379; Hunt and others (89) 118-119; Mathabela and others (n 86) 10-11

²⁹⁴ Hunt and others (89) 118-119

²⁹⁵ Rohleder and others (n 293) 372

²⁹⁶ As above, 373

²⁹⁷ As above

²⁹⁸ As above

McKenzie and others found that the discrimination and inequality that persons with disabilities experience within their homes perpetrated by parental figures adversely impacts their sense of self-worth and esteem, with implications extending to their sexuality.²⁹⁹ Perceived as unworthy, persons with disabilities were discouraged from contemplating sexual activity and procreation.³⁰⁰ Women with disabilities reported that community members expressed surprise regarding the parental status of individuals with disabilities or their desire for marriage.³⁰¹

A significant issue confronting persons with disabilities is the absence of inclusivity within the context of health and society.³⁰² The prevalent stereotypes and discrimination significantly undermine the sexual autonomy of persons with disabilities.³⁰³ The misconception that persons with disabilities lack sexuality has resulted in HCPs disregarding the importance of providing SRHR services to this population.³⁰⁴ Addressing and rectifying misconceptions regarding sexuality and disability is crucial for empowering individuals with disabilities to exercise their SRHR.³⁰⁵ The pursuit of SRHR is of paramount importance and inextricably linked to the advancement of disability rights.³⁰⁶

1.8.5 Intersectionality and disability

Intersectionality has its roots in black feminism and critical race theory,³⁰⁷ and recognises that humans are diverse with multiple social identities, which they can experience multiple forms of discrimination in relation to.³⁰⁸ This then impacts access to healthcare services and facilitates health inequities.³⁰⁹ Variables such as race, sexual orientation and gender identity, disability, age, education, income status and marital status have devastating effects on women's health.³¹⁰

²⁹⁹ JA McKenzie 'Disabled people in rural South Africa talk about sexuality' (2013) 15 (3) *Health and Sexuality* 372-386

³⁰⁰ As above, 383

³⁰¹ As above, 380

³⁰² OA Bolarinwa and others 'Leaving no one behind: addressing the sexuality of people with disabilities' (2024) 23 (129) *International Journal for Equity in Health* 1-3

³⁰³ As above

³⁰⁴ Hunt and other (89) 125

³⁰⁵ Bolarinwa and others (n 302) 2

³⁰⁶ McKenzie (n 299) 386

³⁰⁷ DW Carbado and others 'Intersectionality: Mapping the movements of a theory' (2013) 10(2) *Du Bois Review* 303-312.

³⁰⁸ Wickenden (n 26) 2.

³⁰⁹ RJ Cook 'Human rights and maternal health: Exploring the effectiveness of the Ayne Decision' (2013) *Global Health and the Law* 103-123.

³¹⁰ S Vohra-Gupta and others 'An intersectional approach to understanding barriers to healthcare for women' (2023) 48 *Journal of Community Health* 89-98.

Persons with disabilities may experience discrimination due to multiple factors such as age, economic status, ethnicity, indigeneity, migration status, nationality, race, religion, sexual orientation and gender identity.³¹¹ Girls and young women with disabilities are more likely to face discrimination in healthcare than their counterparts without disabilities, and experience specific human rights violations and aggravated forms of discrimination due to their gender.³¹²

An example of intersectional discrimination encompasses the case of a lesbian woman with mobility and visual impairments who is denied access to fundamental women's health screenings due to the presumption that she is not engaging in penetrative sexual intercourse with a male partner, and consequently does not require cervical cancer screening or contraception. Her visual and mobility impairments constitute physical barriers to accessing information and services, which are further exacerbated by the stigma and discrimination associated with her disabilities, gender, and sexual orientation. HCPs often hold negative views of the bodies, sexuality, and parenting capabilities of women with disabilities.³¹³ An intersectional approach can facilitate a better understanding of healthcare access and experiences in the context of disability.

1.9 Theoretical frameworks

The research inquiry was informed by a combination of conceptual frameworks strategically chosen to address the social and human rights barriers that affect access to SRH services.

1.9.1 Social model approach to disability

The social model approach to disability has been instrumental in shaping the CPRD, helping researchers understand how societal factors affect healthcare access and experiences for persons with disabilities.³¹⁴ Figure 4 illustrates how society's arrangement of the environment can oppress and exclude persons with impairments. Accordingly, the social model of disability suggests that disability emerges from the interactions between individuals with impairments and the physical, attitudinal, and environmental barriers.³¹⁵ It is evident that the social model

³¹¹ UNFPA (n 7).

³¹² As above.

³¹³ Wickenden (n 26) 3.

³¹⁴ Lawson & Beckett (n 277) 351.

³¹⁵ As above, 350.

approach is an essential component in creating a more accessible and inclusive society.³¹⁶ However, it does overlook the fact that persons with disabilities have other identities that may expose them to stigma and discrimination.³¹⁷ Despite this limitation, the social model remains a valuable framework for examining the societal barriers that hinder persons with disabilities from accessing SRH services.

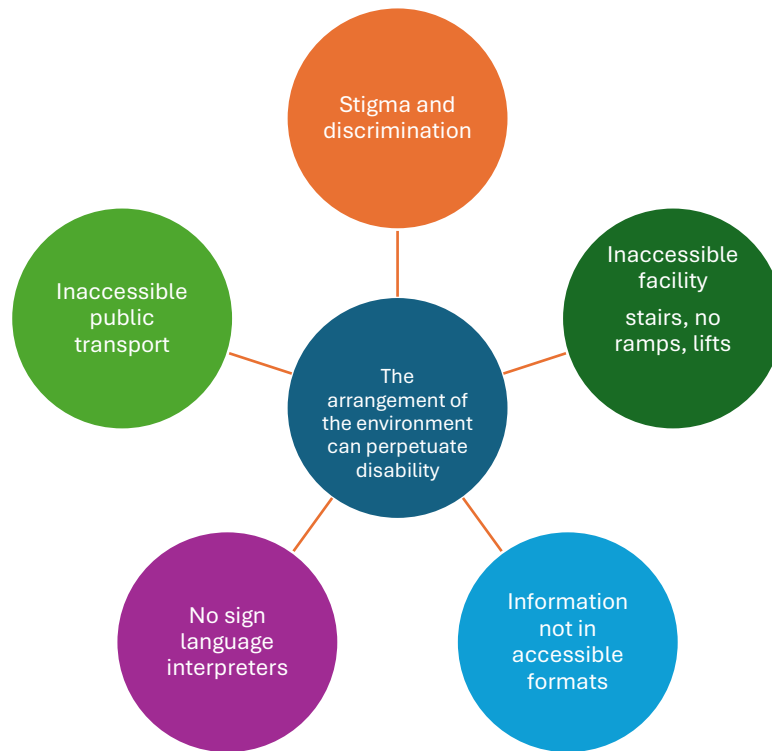


Figure 4. The social model of disability

1.9.2 Penchansky and Thomas' theory of access

According to Saurman, access is recognised as a universal concern and a basic human right.³¹⁸ Penchansky and Thomas conceptualised the theory of access in 1981. Access to health is described as, 'Enabling a patient in need to receive the right care from the right provider at the right time, in the right place, dependent on context.'³¹⁹ The theory of access describes five independent but interconnected dimensions: availability, accessibility, accommodation (adequacy), affordability, and acceptability.³²⁰ Researchers have applied this theoretical

³¹⁶ As above, 354.

³¹⁷ Wickenden (n 26) 1.

³¹⁸ E Saurman 'Improving access: Modifying Penchansky and Thomas's theory of access' (2016) 21(1) *Journal of Health Services Research & Policy* 36-39.

³¹⁹ As above, 37.

³²⁰ Penchansky & Thomas (n 108) 128.

framework to examine access to SRH services,³²¹ while Saurman³²² and Mitchell and others have further refined the theory of access³²³ Saurman introduced awareness as a crucial dimension, asserting that service users are more likely to access and utilise a service if they know about it,³²⁴ and Mitchell and others incorporated the dimension of agency. In the healthcare context, agency refers to individuals ‘personal autonomy to make decisions about accessing, acquiring and avoiding services.’³²⁵

The research inquiry included a modified version of the theory of access, which included the dimensions of awareness and agency (Figure 5). Table 1 provides a description of the dimensions in the modified version of the theory of access.

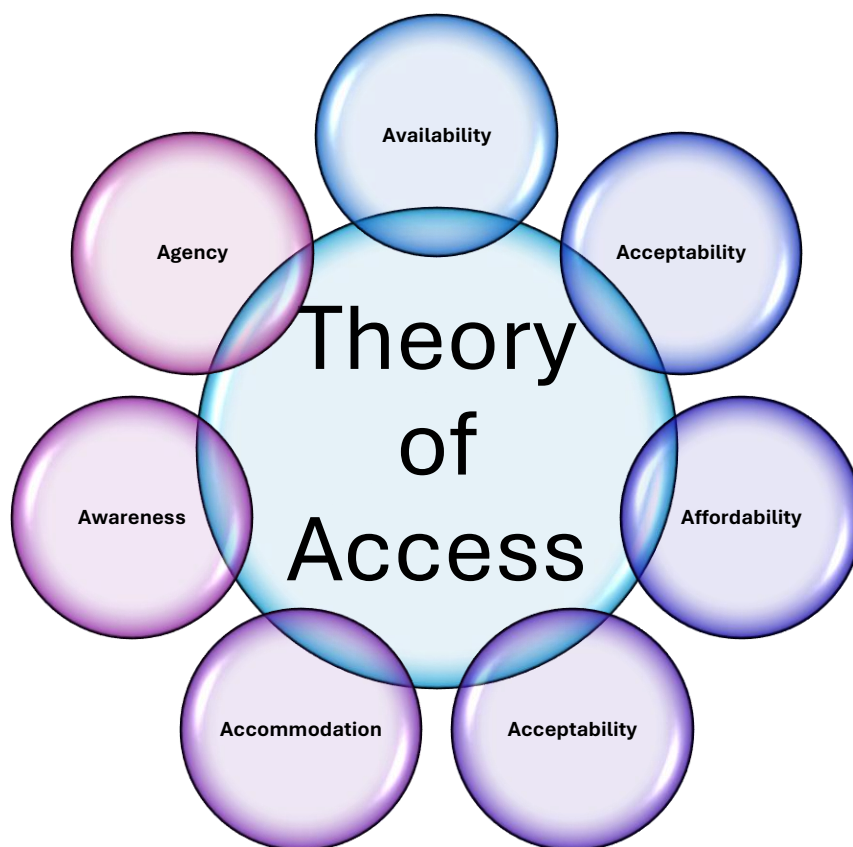


Figure 5: Penchansky and Thomas's theory of access with adaptations from Saurman and Mitchell and others³²⁶

³²¹ A Mitchell and others ‘Contraceptive access experiences and perspectives of Mexican-origin youth: A binational qualitative study’ (2023) 31(1) *Sexual and Reproductive Health Matters* 1-17; Y Kriel and others ‘Access to public sector family planning services and modern contraceptive methods in South Africa: A qualitative evaluation from community and health care provider perspectives’ (2023) 18(3) *PLOS One* 1-20.

³²² Saurman (n 317) 37.

³²³ Mitchell and others (n 321) 4.

³²⁴ Saurman (n 317) 38.

³²⁵ Mitchell and others (n 317) 4.

³²⁶ As above.

Table 1: Description of the dimensions in adapted Penchansky and Thomas's theory of access³²⁷

Dimension	Description
Availability	SRH services and resources are sufficiently available (volume and type) to meet the volume and needs of users. Trained HCPs are available to deliver SRH services. Contraception and other SRH consumables are available. In the context of disability inclusive SRH services, the availability of HCPs trained in sign language is important.
Accessibility	SRH services are located (location of supply and location of users) near users. Factors related to accessibility include transportation, travel time, distance, social/family support and cost).
Accommodation	The configuration of SRH services and resources to accept or accommodate users such as appointment system, hours of operation, facility infrastructure, and SRH information. Accommodation is critical to meet the needs of persons with disabilities. In healthcare settings, reasonable accommodation measures include ramps, accessible toilets, providing information in braille, and height adjustable equipment. Access to sign language interpreters to accommodate the needs of persons with disabilities is also an important factor in the dimension of accommodation
Affordability	The users' perceptions of the financial costs of the SRH services. These include the user's ability to pay direct and indirect costs of SRH services
Acceptability	Acceptability encompasses the attitudes of the HCPs and users towards each other (interactions), including the characteristics of the SRH services, social and cultural concerns. Acceptability also refers to stigma and discrimination.
Awareness	Awareness of SRH services is communicated effectively and there is information sharing to foster health literacy. Awareness also refers to HCPs being aware of the population's needs.

³²⁷ Mitchell and others (n 321) 4.

Dimension	Description
Agency	The term agency refers to an individual's personal ability to make decisions about accessing, obtaining, and avoiding services.

The theory of access was included to assess the experiences and challenges faced by persons with disabilities in accessing SRH services, given its similarities between the right to health framework established by the Committee on Economic, Social, and Cultural Rights (CESCR) in General Comment 14. Here, the right to health encompasses four interrelated standards on healthcare services, namely accessibility, acceptability, availability, and quality, collectively known as the AAAQ framework.³²⁸ Figure 5 depicts the AAAQ framework.

Accessibility in the AAAQ framework includes non-discrimination, physical accessibility to the buildings and infrastructure, economic accessibility (affordability) and information accessibility (right to seek, receive and impart information).³²⁹ Acceptability refers to providing health services that adhere to medical ethics and are culturally sensitive.³³⁰ Quality requires that services be scientifically and medically appropriate (skilled personnel, non-expired drugs, and equipment).³³¹ The provision of health necessitates that functioning public health facilities, services, and goods are operational and available in adequate quantities.³³² Kriel and others posit that the Penchansky and Thomas framework offers the most extensive examination of access to health.³³³

³²⁸ UN Committee on Economic, Social and Cultural Rights (Committee on ESCR) General Comment No 14, UN Doc E/C/12/2000/4 para 21.

³²⁹ As above, para 12 b.

³³⁰ As above, para 12 c.

³³¹ As above, para 12 d.

³³² As above, para 12 a.

³³³ Y Kriel and others 'Access to public sector family planning services and modern contraceptive methods in South Africa: A qualitative evaluation from community and health care provider perspectives' (2023) 18(3) *PLOS One* 1-20.

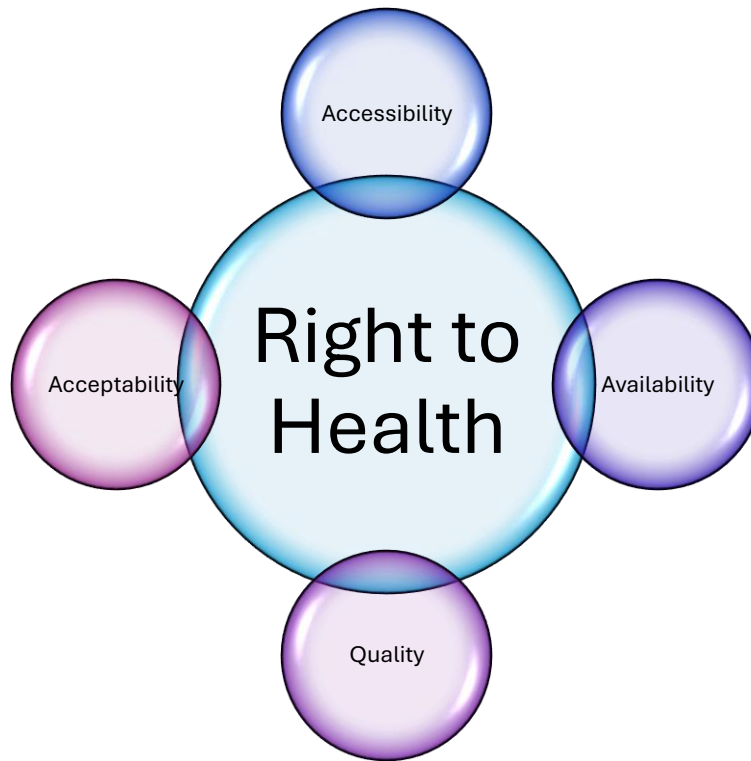


Figure 5: The AAAQ framework

1.10 Chapter overview

Chapter 1 of the study covered the background information, terminology, problem statement, research questions, research methodology, significance of the research, literature review, and theoretical framework. Chapter 2 provides an analysis of 1) South Africa's legal obligations to facilitate access to SRHR for persons with disabilities; 2) the inclusivity of disability in SRH policies and strategic frameworks; and 3) gaps in the identified policies and strategic frameworks regarding the SRHR of persons with disabilities. Chapter 3 presents the methodology, findings and discussion of the scoping review on how persons with disabilities experience access to SRH in public healthcare settings and their challenges in accessing SRH services. Finally, Chapter 4 shares the conclusion and recommendations from this study.

Chapter 2. Human rights law and policy framework

2.1 Introduction

Chapter 2 evaluates South Africa's legal responsibility to ensure that persons with disabilities have access to SRHR. It also examines the extent to which disability is included in existing SRH policies and frameworks, highlighting gaps in these policies regarding the SRHR of persons with disabilities.

SRHR are integral to and safeguarded by international and regional human rights agreements.³³⁴ South Africa has committed to the obligations of these international and regional human rights agreements, incorporating their human right standards into its national legal and policy framework. International and regional human rights instruments ensure that SRH is a fundamental right for all individuals, including those with disabilities. Shale posits that SRHR include key human freedoms, such as equality, non-discrimination, the right to marry and establish a family, access to reproductive healthcare services, the capacity to provide informed consent for medical interventions, and the right to be protected from sexual violence and exploitation.³³⁵

2.2 International human rights framework

The 1948 Universal Declaration of Human Rights (UDHR) marked a seminal moment in human history, introducing the world to the concept of human rights.³³⁶ The WHO assumed responsibility for global health governance, focusing on a human rights approach to public health under the auspices of international law.³³⁷ The right to health was included in the 1946 preamble to the Constitution of the WHO.³³⁸ Article 25 of the UDHR recognises the interrelated importance of health, socioeconomic, and social rights by emphasising:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services, and the right to

³³⁴ R Tallarico and others 'Age of consent: A case for harmonising laws and policies to advance, promote and protect adolescents' sexual and reproductive health rights' (2021) 25(2) *African Journal of Reproductive Health* 94-102.

³³⁵ Shale (n 123) 38.

³³⁶ Universal Declaration on Human Rights, GA Res 217A (III), UN Doc A/811 (1948) UN.

³³⁷ BM Meier and others 'Human rights in public health: Deepening engagement at a critical time' (2018) 20(2) *Health Human Rights*. 85-91.

³³⁸ BM Meier 'Human rights in the World Health Organization: Views of the Director-General candidates' (2017) 19(1) *Health Human Rights*. 293-298.

security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.³³⁹

The UDHR explicitly prohibits discrimination on the grounds of race, sex, language, religion, colour, and other status, in addition to asserting that ‘all humans are born free and equal.’³⁴⁰ The interpretation of the concept of ‘other status’ in Article 2 of the UDHR can be expanded to incorporate disability. The UDHR serves as the foundational document for the CRPD.

The 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) is the leading international human rights instrument concerning the ‘right to health’.³⁴¹ CESCR General Comment 5 acknowledges that the ICESCR does not explicitly mention persons with disabilities,³⁴² however, they are entitled to the full range of rights in the Covenant. The Covenant’s lack of specific disability-related provisions was due to the lack of widespread recognition of the importance of addressing this matter during its drafting.³⁴³

Article 12 of the ICESCR guarantees ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’³⁴⁴ CESCR General Comment 14 specifies that this includes the right to SRH.³⁴⁵ General Comment 14 also emphasises that access to healthcare, including SRH services, should not be hindered by discrimination or physical, economic, or information barriers.³⁴⁶ Persons with disabilities should not be subjected to discrimination and should have unrestricted physical accessibility to buildings in healthcare settings.³⁴⁷

CESCR General Comment 22 elaborates on the right to health, building on General Comment 14 by emphasising that persons with disabilities should not only receive the same level and quality of SRH services as others, but also specialised services to meet their unique needs as a result of their disabilities.³⁴⁸ CESCR draws attention to the issue of intersectionality and multiple discrimination, which disproportionately affects marginalised communities, such

³³⁹ Art 25, UDHR.

³⁴⁰ Art 1 & 2, UDHR.

³⁴¹ LN Murungi & E Durojaye ‘The sexual and reproductive health rights of women with disabilities in Africa: Linkages between the CRPD and the African Women’s Protocol’ (2015) 3 African Disability Rights Yearbook 1-30; International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

³⁴² UNCESCR CESCR General Comment 5: Persons with Disabilities UN Doc E/1995/22

³⁴³ As above, para 6.

³⁴⁴ Art 12, ICESCR.

³⁴⁵ General Comment 14 (n 328) para 21.

³⁴⁶ As above, para 12 b.

³⁴⁷ As above, para 18.

³⁴⁸ UNCESCR General Comment 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) UN Doc E/C.12/GC/22.

as persons with disabilities, in the context of SRH.³⁴⁹ States must put in place mechanisms to tackle discrimination and disparities in order to fully realise the rights to SRH. Moreover, they should revise laws and policies, prioritising equality and non-discrimination to enable the realisation of SRHR.³⁵⁰ In this regard, policies and frameworks for SRH should also be inclusive of persons with disabilities. The obligations of states necessitate the development and execution of a national strategy and action plan, accompanied by an appropriate financial allocation, to promote and support SRH. States should eliminate physical and geographic obstacles that impede access to SRH services and ensure universal access to these services fairly and equitably. Additionally, it is necessary to establish legal frameworks that prohibit harmful practices, GBV, child marriage, sexual violence, and marital rape.³⁵¹ The CESCR has recognised that there is a heightened need to achieve the goals and targets related to SRH for the success of the 2030 Agenda for Sustainable Development.³⁵² This includes ensuring that inclusivity is maintained and that vulnerable groups such as persons with disabilities are not left behind.

The 1981 Convention on the Elimination of Discrimination Against Women (CEDAW), often referred to as the Bill of Rights for Women, also recognises the SRHR of women with disabilities.³⁵³ The CEDAW Committee urges states in its General Recommendation 18,

To provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life.³⁵⁴

South Africa ratified the CRPD and its Optional Protocol on 30 November 2007.³⁵⁵ The CRPD stipulates in Article 25(a) that persons with disabilities should have equal access to a wide range of high-quality healthcare services and programmes, including SRH care, for persons without disabilities.³⁵⁶ Article 5 of the CRPD emphasises that states must provide reasonable accommodation for persons with disabilities to ensure equality and non-discrimination.³⁵⁷ In

³⁴⁹ As above, para 30.

³⁵⁰ As above, para 34.

³⁵¹ As above, para 49.

³⁵² As above, para 1.

³⁵³ Shale (n 123) 39.

³⁵⁴ UN Committee on the Elimination of Discrimination against Women CEDAW General Recommendation 18 on Article 3: Disabled women 1991 A/46/38

³⁵⁵ C Ngwenya and others 'Introduction' in C Ngwenya, I Grobelaar-du Plessis, J Njau & I Mgijima -Knopi (eds) *South Africa disability legislation and policy gap analysis* 2015, <https://policycommons.net/artifacts/3759285/south-africa-disability-legislation-policy-gap-analysis/4564834> (accessed 15 May 2024)

³⁵⁶ Art 25, CRPD.

³⁵⁷ Art 5, CRPD.

General Comment 6 on equality and non-discrimination, the UN CRPD Committee claims that states have typically approached disability through charity or medical models, which are incompatible with the principles it outlines.³⁵⁸ This approach has been described as reinforcing stigma, prejudices, and stereotypes against persons with disabilities.³⁵⁹ The human rights model of disability promotes inclusive equality for persons with disabilities. According to the UN CRPD Committee, excluding persons with disabilities from national laws and frameworks and denying them reasonable accommodation serves to amplify discrimination.³⁶⁰ The provision of reasonable accommodation for persons with disabilities is essential for ensuring non-discrimination. The concept of reasonable accommodation involves providing accessible facilities and information for persons with disabilities, adapting equipment, rearranging activities, adjusting work schedules, modifying learning materials and teaching strategies, making changes to medical procedures, and providing access to support personnel without imposing costs, unequal or unnecessary burden on persons with disabilities.³⁶¹

General Comment 6 also underlines how intersectional discrimination affects the enjoyment of human rights for persons with disabilities. For instance, denying family planning services to a visually impaired woman restricts her rights at the intersection of her gender and disability.³⁶² The full implementation of Article 5 requires the creation of anti-discrimination laws, the alteration and abolition of discriminatory customs, the establishment of discriminatory protection laws, and the alignment of the legal and policy framework with the CRPD.³⁶³

General Comment 3 on Article 6 of the CRPD, which concerns women and girls with disabilities, stipulates that states must protect the SRHR of persons with disabilities,³⁶⁴ acknowledging that harmful stereotypes and beliefs affect women and girls with disabilities, perpetuating the idea that they are asexual, incapable of bearing and parenting children, irrational, or hypersexual.³⁶⁵ In contrast to existing harmful stereotypes and beliefs, General Comment 3 clarifies that women with disabilities have the right to control their reproduction, deciding freely on the number and spacing of their children, and the right to autonomy over

³⁵⁸ UN Committee on the Convention on the Rights of Persons with Disabilities (CRPD Committee) General Comment 6 on equality and discrimination (2018) UN Doc CRPD/C/GC/6

³⁵⁹ As above, para 2.

³⁶⁰ As above, para 3.

³⁶¹ As above, para 24.

³⁶² As above, para 3.

³⁶³ South African Law Reform Commission *Domestication of the United Nations Convention on the Rights of Persons with Disabilities* (9 December 2020) 1-199.

³⁶⁴ CRPD Committee (n 358).

³⁶⁵ As above, para 38.

their sexuality.³⁶⁶ The recommendations urge states to revoke discriminatory laws that hinder the rights of women and girls with disabilities. These include forced sterilisation, forced abortion, non-consensual contraception, and the outlawing of gender and disability-based discrimination.³⁶⁷ In addition, states must adopt laws and policies that are inclusive of persons with disabilities, protecting the rights of women and girls with disabilities.³⁶⁸ The UN CRPD Committee emphasises the responsibility of states to ensure that SRH facilities, information, and services are accessible, available, and affordable for persons with disabilities.³⁶⁹

In 2018, the UN CRPD and CEDAW Committees issued a joint statement advocating for the protection of SRHR for persons with disabilities.³⁷⁰ There were growing concerns regarding diminishing respect for international human rights norms and the detrimental consequences it could have on the SRHR of women, including women with disabilities.³⁷¹ The joint statement by the Committees calls on states to address intersectional discrimination and protect the rights to life, health, equality before the law, equal protection of the law, information, privacy, bodily integrity and freedom from torture and ill-treatment.³⁷² There was consensus that states must implement measures to protect women with disabilities from forced abortion, contraception and sterilisation.³⁷³ The Committees called for discriminatory health policies and abortion laws to be repealed as they perpetuate deeply entrenched stereotypes and stigma.³⁷⁴ As outlined in the joint statement, decriminalisation of abortion is a critical step to achieving gender equality.³⁷⁵ In addition, the Committees emphasised the necessity for states to adopt and put into practice a human rights approach in order to guarantee the reproductive freedom and autonomy of all women, including women with disabilities.³⁷⁶

³⁶⁶ As above, para 39.

³⁶⁷ As above, para 62 (i).

³⁶⁸ As above, para 62 (ii).

³⁶⁹ As above, para 65.

³⁷⁰ Women with Disabilities Australia 'UN CRPD and CEDAW Committees call for the guarantee of Sexual and Reproductive Health and Rights for women with disabilities', 6 September 2018, <https://www.wwda.org.au/2018/09/crpd-cedaw-joint-statement-reprorights/> (accessed 20 June 2024).

³⁷¹ Women with Disabilities Australia (n 370).

³⁷² UN CEDAW & CRPD Committees 'Joint statement 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities' 29 August 2018, https://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/JointStatement_UNW_CEDAW_CRPD.docx (accessed 21 June 2024)

³⁷³ UN CEDAW & CRPD Committees (n 372).

³⁷⁴ As above.

³⁷⁵ As above.

³⁷⁶ As above.

Courts across the globe have adjudicated the reproductive rights of adolescent girls and young women with disabilities.³⁷⁷ In India, the case of *Suchita Srivastava v Chandigarh Administration*³⁷⁸ highlighted the fact that having an intellectual disability should not serve as a justification for denying an individual reproductive autonomy. The case concerned Suchita, an individual with a mild intellectual disability who became pregnant as a result of rape.³⁷⁹ The Chandigarh Administration approached the Punjab and Haryana High Court requesting approval to terminate the pregnancy, citing grounds that Suchita had an intellectual disability, was an orphan, and lacked the necessary parental support and capacity to raise the child.³⁸⁰ The High Court granted Chandigarh Administration approval to terminate the pregnancy despite Suchita expressing her willingness to bear a child.³⁸¹ However, the Supreme Court of India overturned the High Court's decision, citing that under Article 21 of the Indian Constitution, Suchita had the right to reproductive choice and the right to liberty. In accordance with the provisions of Section 3 of the Medical Termination Act, the Supreme Court noted that the termination of pregnancy could not be ordered without Suchita's consent.³⁸² The Supreme Court emphasised that Suchita's privacy, dignity, and bodily integrity should be respected. Furthermore, it pointed out that India had an obligation under the CRPD to ensure respect for the reproductive choice of women with disabilities.³⁸³ This case is significant in the global discourse surrounding the validation of the reproductive rights of women with disabilities.

2.3. Regional human rights framework

The African Charter on Human and Peoples' Rights (African Charter) is the cornerstone of Africa's regional human rights system.³⁸⁴ Article 2 forthrightly upholds the right of every individual to be free from any form of discrimination, regardless of their race, colour, religion, ethnicity, sex, national and social origin, language, or any other such distinction. Disability can be considered an integral part of the 'other status' category, emphasising the importance of

³⁷⁷ These include *E. (Mrs) v Eve* (1986) 2 SCR 388; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) HCA 15, (1992) 175 CLR 218; *Tysiac v Poland*, (2007), ECtHR, Application 5410/03; *Suchita Srivastava v Chandigarh Administration* (2009) 14 SCR 989, (2009) 9 SCC 1; *Z v State of Bihar & Ors* (2018) 11 SCC 572.

³⁷⁸ *Suchita Srivastava v Chandigarh Administration* (2009) 14 SCR 989, (2009) 9 SCC 1.

³⁷⁹ As above, para 2.

³⁸⁰ As above, para 2.

³⁸¹ As above, para 22.

³⁸² As above, para 24.

³⁸³ As above, para 26.

³⁸⁴ African Charter on Human and Peoples' Rights (African Charter) OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity on 27 June 1981, entered into force on 21 October 1986.

inclusion and diversity.³⁸⁵ Article 16 affirms that every individual has the right to access the highest attainable standard of physical and mental health.³⁸⁶ Therefore, states are obligated to safeguard all citizens' health and provide suitable medical care. The African Charter ensures the protection of persons with disabilities as outlined in Article 18(4): 'The aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.'³⁸⁷ Despite this, Combrink highlights that Article 18(4) has faced criticism for its ambiguity, which conflates the rights of the elderly with those of persons with disabilities.³⁸⁸

The right to health for persons with disabilities was affirmed in *Purohit & Moore v The Gambia*³⁸⁹ where the African Commission determined that The Gambia had failed to fulfil the requirements of articles 16 and 18(4). Furthermore, the African Commission deemed the Lunatic Detention Act (Act) in The Gambia to be discriminatory as it allowed the detention of vulnerable persons from the streets and poor socioeconomic backgrounds.³⁹⁰ The Act also prescribed derogatory terminology like 'idiots' and 'lunatics' to describe persons with mental illness.³⁹¹ The African Commission declared that persons with disabilities were entitled to healthcare without discrimination. The case of *Purohit & Moore v The Gambia* demonstrates how states can be held accountable for protecting the right to health for persons with disabilities by invoking the African Charter.

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (African Women's Protocol) recognises and promotes women's rights to SRH in Africa.³⁹² General Comment 2 - an expansion on Article 14 of the African Women's Protocol, which focuses on women's SRHR - emphasises that states must not hinder women's autonomy in making decisions related to their SRH.³⁹³ The African Women's Protocol is a groundbreaking human rights treaty that explicitly safeguards the rights of women by urging states to sanction medical abortions in situations involving rape, sexual assault, or incest, where the expectant mother's mental and physical health or her life is at risk.³⁹⁴ Murungi and Durojaye highlight

³⁸⁵ LO Louis 'Africa at crossroads: The United Nations Convention on the Rights of Persons with Disabilities' (2015) 30(2) *University International Law Review* 347-377.

³⁸⁶ Art 16, African Charter.

³⁸⁷ Art 18 (4), African Charter.

³⁸⁸ H Combrink 'Disability rights in the African regional human rights system during 2011 and 2012' (2013) 1 *African Disability Rights Yearbook* 361-367.

³⁸⁹ *Purohit & Moore v The Gambia*, Communication No.24/2001 (2003).

³⁹⁰ As above.

³⁹¹ As above.

³⁹² Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), adopted by the 2nd ordinary session of the Assembly of the African Union, Maputo, CAB/LEG/66.6.

³⁹³ General Comment 2 on Arts 14(1)(a), (b), (c) and (f) and Arts 14(2)(a) and (c) of the African Women's Protocol adopted by the African Commission at its 55th ordinary session held from 28 April to 12 May 2014 in Luanda, Angola.

³⁹⁴ Art 14 (c), African Women's Protocol.

that the inclusion of non-discrimination and dignity in the African Women's Protocol is crucial in addressing discriminatory practices against women with disabilities.³⁹⁵ In fact, General Comment 2 on Article 14 stipulates that States are obligated,

To provide services that are comprehensive, integrated, rights-based, sensitive to the reality of women in all contexts, and adapted to women living with disabilities and the youth, free from any coercion, discrimination, and violence.³⁹⁶

Article 23 of the African Women's Protocol focuses specifically on providing special protection for women with disabilities by mandating that states facilitate their access to employment, vocational and professional training, and decision-making processes, all of which must be tailored to meet their unique physical, economic, and social needs.³⁹⁷ Moreover, it recommends that states eradicate discrimination against women on grounds of disability, and protect them from violence and sexual abuse.³⁹⁸ The provisions specific to women with disabilities may be interpreted to encompass access to healthcare, including SRH services.³⁹⁹

South Africa has signed and ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Disability Rights Protocol).⁴⁰⁰ The protocol mirrors the CRPD and seeks to advance and protect the rights of persons with disabilities from an African perspective.⁴⁰¹ The guiding principles of the African Disability Rights Protocol include respect for inherent dignity, privacy, individual autonomy, non-discrimination, full participation and inclusion, respect for difference and acceptance, equal opportunity, accessibility, reasonable accommodation, equality between men and women, the best interests of the child, and respect for the evolving capacities of children with disabilities.⁴⁰² The protocol concedes that persons with disabilities routinely confront accessibility obstacles resulting from barriers in the physical environment, transportation, information and communication technologies, facilities, and services.⁴⁰³ Consequently, states

³⁹⁵ Murungi & Durojaye (n 341) 9.

³⁹⁶ General Comment 2 (n 393) para 53.

³⁹⁷ Murungi & Durojaye (n 341) 9.

³⁹⁸ Art 23 (b) African Women's Protocol.

³⁹⁹ Murungi & Durojaye (n 341) 9.

⁴⁰⁰ African Union (AU) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (29 January 2018) (African Disability Rights Protocol).

⁴⁰¹ African Disability Forum 'Protocol to the African Charter on Human and Peoples Rights on the Rights of Persons with Disabilities in Africa' 21 December 2023, <https://africandisabilityforum.net/press-release-protocol-to-the-african-charter-on-human-and-peoples-rights-on-the-rights-of-persons-with-disabilities-in-africa/#> (accessed 16 May 2024).

⁴⁰² Art 3, African Disability Rights Protocol.

⁴⁰³ Art15 (1), African Disability Rights Protocol.

are responsible for implementing reasonable accommodations in urban and rural settings, buildings, infrastructure, roads, transportation, communications, and information.⁴⁰⁴

Article 17 of the African Disability Rights Protocol guarantees the rights of persons with disabilities to the ‘highest attainable standard of health.’ Accordingly, states are required to implement measures to facilitate access to health services, including SRH services for persons with disabilities.⁴⁰⁵ These include prohibiting discrimination against persons with disabilities by HCPs, ensuring informed consent, using accessible formats and effective communication, ensuring supported decision-making, hosting disability inclusive health campaigns, and training HCPs in disability-specific needs and rights.⁴⁰⁶ Undoubtedly, the African Disability Rights Protocol has been praised for its bold step in not only recognising that the right to health is inclusive of SRHR, but also including provisions that address the SRH challenges experienced by persons with disabilities.⁴⁰⁷

2.4 South Africa’s policy framework regarding disability inclusion in SRH

This study examined the South African Constitution and the policy framework regarding disability inclusion in SRH. The comprehensive legislative framework encompassing the Mental Health Act⁴⁰⁸, the National Health Act⁴⁰⁹, the Children's Act⁴¹⁰, Choice of Termination Act⁴¹¹, Sterilisation Act⁴¹² were not examined in this study.

The Constitution safeguards the fundamental rights and freedoms of all individuals living in South Africa, including persons with disabilities. These include the right to life, equality, privacy, freedom and security of person, and human dignity.⁴¹³ Section 9 of the Constitution explicitly prohibits discrimination on the grounds of disability. In accordance with Section 12(2), it is guaranteed that everyone possesses the ‘right to bodily and psychological integrity.’ This provision further elaborates on several specific rights, including:

- 1) The right to make decisions regarding reproduction

⁴⁰⁴ Art 15(2), African Disability Rights Protocol.

⁴⁰⁵ Art 17 (1), African Disability Rights Protocol.

⁴⁰⁶ Art 17 (2), African Disability Rights Protocol.

⁴⁰⁷ Murungi & Durojaye (n 341) 14.

⁴⁰⁸ Mental Health Care Act 17 of 2002

⁴⁰⁹ National Health Act 61 of 2003

⁴¹⁰ Children’s Act of 2005

⁴¹¹ Choice of Termination Act 92 of 1996

⁴¹² Sterilisation Act 44 of 1998

⁴¹³ Constitution of the Republic of South Africa, 1996 (Constitution).

2) The right to security in and control over their body and

3) The right not to be subjected to medical and scientific experiments without their informed consent.⁴¹⁴

Importantly, Section 27 of the Constitution asserts the fundamental right of all individuals to access comprehensive healthcare services, including reproductive healthcare.⁴¹⁵ South Africa has implemented various health policies concerning HIV, SRHR, and GBV. An important objective of this study was to assess the extent to which disability is included in existing SRH policies and frameworks, while also highlighting gaps regarding the SRHR of persons with disabilities.

The United Nations Population Fund (UNFPA) developed the SRHR and Disability Policy and Programme Analysis Tool (Tool) to examine the inclusion of disability in SRHR policies and plans and the inclusion of SRHR elements in disability policies and plans.⁴¹⁶ Hanass-Hancock and others have utilised the Tool to analyse the level of disability inclusion or exclusion of SRHR issues in SRH and disability-related policies and strategic frameworks in South Africa.⁴¹⁷ The Tool requires researchers to systematically search for policies, plans, and strategic frameworks pertinent to SRHR and disability.⁴¹⁸ The inclusion of relevant policies, programmes, plans, and strategic frameworks is presented under the following categories: 1) Constitution and relevant acts; 2) National SRHR and HIV policies; 3) National disability policies or acts; 4) National SRHR and HIV strategic plans or frameworks; and 5) National strategic plans on disability.⁴¹⁹ Further, the Tool analyses the recognition of persons with disabilities as a vulnerable group and the protection and promotion of rights for persons with disabilities.⁴²⁰ Turning to the evidence from the Sexual and Reproductive Health and Rights and Disability Policy Analysis Report 2021⁴²¹, the principal researcher examined the extent of disability inclusion or exclusion of SRHR issues in SRH and disability-related policies and strategic frameworks in South Africa.

This study also included an evaluation of national SRHR policies that were not previously examined in the Sexual and Reproductive Health and Rights and Disability Policy

⁴¹⁴ Section 12 (2), Constitution.

⁴¹⁵ Section 27, Constitution.

⁴¹⁶ UNFPA (n 44).

⁴¹⁷ Hanass-Hancock and others (n 75) 11.

⁴¹⁸ UNFPA (n 44), 89.

⁴¹⁹ As above, 91.

⁴²⁰ As above, 92.

⁴²¹ Hanass-Hancock and others (n 75) 4.

Analysis Report. By taking a comprehensive approach, the aim was to fully assess the inclusion of disability in SRHR policies and frameworks in South Africa.

Table 2 presents the policies, plans, and strategic frameworks pertaining to SRHR and disability reviewed in the Sexual and Reproductive Health and Rights and Disability Policy Analysis Report. Subsequently, Tables 3 and 4 exhibit the policies and frameworks that have attempted to address persons with disabilities and recognise them as a susceptible group, respectively. Table 5 displays policies and frameworks addressing the protection and promotion of rights for persons with disabilities.

*Table 2: The policies, plans, and strategic frameworks pertaining to SRHR, and disability reviewed by Hanass-Hancock and others as presented in the South Africa Case Report: Sexual and Reproductive Health and Rights and Disability Policy Analysis.*⁴²²

National SRHR & HIV Policies	National Disability Policies or Acts	National SRHR and HIV Strategic Plans or Frameworks	National Strategic Plans on Disability
DoH Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond. Integrated School Health Policy 2012 National HIV Testing Services: Policy 2016 Adolescent & Youth Health Policy 2016-2020	White Paper on the Rights of Persons with Disabilities 2015	DPSA Strategic Framework for Public Service HIV & AIDS Response 2012 Integrated Youth Development Strategy of South Africa (IYDS) 2012-2016 National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019	Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020

⁴²² As above, 5.

National SRHR & HIV Policies	National Disability Policies or Acts	National SRHR and HIV Strategic Plans or Frameworks	National Strategic Plans on Disability
Department of Basic Education (DBE) National Policy on HIV, STIs and TB June 2017 Sexually Transmitted Infections: Management Guidelines 2018		She Conquers Campaign: Focus on adolescent girls and young women 2016 National Strategic Plan for HIV, STIs and TB 2017-2022 Policy Framework to address Gender Based Violence in the Post-School Education and Training System 2020 National Strategic Plan on Gender-Based Violence and Femicide 2020	

Table 3: Policies and frameworks that have taken steps to address persons with disabilities⁴²³

Policies and frameworks
DoH Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond
National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019, 2015
National Strategic Plan for HIV, STIs and TB 2017-2022
National Strategic Plan on Gender-Based Violence and Femicide 2020

Table 4 Policies and frameworks addressing persons with disabilities as a vulnerable population⁴²⁴

Policies and frameworks
National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014
The National HIV Testing Services Policy 2016
Adolescent & Youth Health Policy 2016
DBE National Policy on HIV, STI and TB 2017
National Strategic Plan 2017-2022
National Strategic Plan on Gender Based Violence and Femicide 2020

⁴²³ Hanass-Hancock and others (n 75) 5.

⁴²⁴ As above.

Table 5 Policies and frameworks addressing the protection and promotion of rights for persons with disabilities⁴²⁵

Policies and frameworks
DoH Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011- 2021 and beyond.
National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014
National Strategic Plan 2017-2022
National Strategic Plan on Gender Based Violence and Femicide 2020

National SRHR and HIV policies

The National HIV Testing Services (HTS) Policy acknowledges the importance of human rights and the right to access HTS.⁴²⁶ It also identifies persons with disabilities as a vulnerable population. While it mentions that facilities should be accessible to persons with disabilities, it lacks specific recommendations on how to make the services accessible to this group. Furthermore, it does not address the issue of providing reasonable accommodations for persons with disabilities. The Sexually Transmitted Infections: Management Guidelines 2018 fails to provide any consideration for persons with disabilities.⁴²⁷

The Integrated School Health Policy does not classify learners with disabilities as a vulnerable population.⁴²⁸ In contrast, the DBE HIV, STI, and Tuberculosis (TB) Policy⁴²⁹ recognises persons with disabilities as a vulnerable group susceptible to a higher risk of HIV, STI and TB infection. Furthermore, the Policy states that the DBE will address the needs of learners with disabilities and ensure their access to inclusive education. Despite recognising the significance of access to CSE and SRH, the aforementioned policies do not address the provision of reasonable accommodations for learners with disabilities to access CSE.

⁴²⁵ As above.

⁴²⁶ DoH 'National HIV Testing Services Policy' 2016, <https://knowledgehub.health.gov.za/elibrary/national-hiv-testing-services-policy> (accessed 19 May 2024).

⁴²⁷ DoH 'Sexually Transmitted Infections: Management Guidelines' 2018, <https://www.health.gov.za/wp-content/uploads/2020/11/sti-guidelines-27-08-19.pdf> (accessed 19 May 2024)

⁴²⁸ DBE 'Integrated School Health Policy' 2017, <https://serve.mg.co.za/content/documents/2017/06/14/integratedschoolhealthpolicydbeanddoh.pdf> (accessed 19 May 2024).

⁴²⁹ DBE 'HIV, STI and TB Policy' 2017, <https://www.education.gov.za/LinkClick.aspx?fileticket=SFXp9rXC9AM%3D&tabid=390&portalid=0&mid=1125> (accessed 19 May 2024).

The Adolescent and Youth Health Policy 2016-2020 identifies that adolescents and youth living with disabilities have been excluded from SRH policies despite their engagement in high-risk sexual behaviour.⁴³⁰ Nevertheless, this policy lacks recommendations for improving access to SRH services for adolescents and youths living with disabilities.

The DoH Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and Beyond addresses persons with disabilities by acknowledging their vulnerability and mandating that health services provide physical access to persons with disabilities and communication access in braille and sign language.⁴³¹ Additionally, it cites the CRPD regarding the provision of reasonable accommodation for persons with disabilities.

The 2021 National Integrated Sexual and Reproductive Health and Rights Policy acknowledges persons with disabilities as a vulnerable population.⁴³² It strongly asserts that persons with disabilities are entitled to receive respectful and non-judgmental SRHR services. The Policy also advises that it is crucial that persons with disabilities are granted complete autonomy, choice, and control over their sexuality and relationships.⁴³³ The Policy mandates that facilities decisively eliminate barriers for persons with disabilities to access information by providing it in braille and sign language. Moreover, the Policy stipulates that facilities must consider the distance from users' homes, entrance and exit structures, and facilities' layout. SRHR facilities need to be wheelchair accessible, with priority for persons with disabilities.⁴³⁴ The South African Maternal, Perinatal, and Neonatal Health Policy 2021 recognises persons with disabilities as a vulnerable population but surprisingly does not provide specific provisions addressing their healthcare needs.⁴³⁵

The 2019 National Contraception Clinical Guidelines consider the needs of persons with disabilities,⁴³⁶ and stress the importance of respecting persons with disabilities, cautioning against coercing them into sterilisation. Importantly, they address and recommend the crucial concept of supported decision-making (SDM) for persons with disabilities. SDM occurs when

⁴³⁰ DoH 'Adolescent & Youth Health Policy for 2016-2020' 2017, <https://knowledgehub.health.gov.za/elibrary/national-adolescent-and-youth-health-policy-2017> (accessed 19 May 2024).

⁴³¹ DoH 'Health Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021' 2012, <http://www.agenda.org.za/wp-content/uploads/2012/09/SRHR-Fulfilling-our-Commitments.pdf> (accessed 19 May 2024).

⁴³² DoH 'National Integrated Sexual and Reproductive Health and Rights Policy 2021' 2020, <https://knowledgehub.health.gov.za/elibrary/national-integrated-sexual-reproductive-health-and-right-policy-2020> (accessed 19 May 2024).

⁴³³ As above, 20.

⁴³⁴ As above, 30.

⁴³⁵ DoH 'South African Maternal, Perinatal, and Neonatal Health Policy' 2021, <https://knowledgehub.health.gov.za/elibrary/south-african-maternal-perinatal-and-neonatal-health-policy> (accessed 19 May 2024).

⁴³⁶ DoH 'National Contraception Clinical Guidelines' 2019, <https://knowledgehub.health.gov.za/elibrary/national-contraception-clinical-guidelines-2019> (accessed 19 May 2024)

a third party helps and supports the decisions of persons with intellectual disabilities.⁴³⁷ Article 12 of the CRPD also endorses SDM to ensure that persons with disabilities enjoy their autonomy and legal capacity.⁴³⁸ Consequently, the CRPD Committee's General Comment 1 on Article 12 highlights SDM as an imperative aspect of the human rights model approach to disability.⁴³⁹ In accordance with the CRPD, States are obligated to develop and implement legislation that establishes SDM as an alternative to orthodox decision-making systems, such as guardianship and trusteeship.⁴⁴⁰ Series and Nilsson argue that SDM places PWD 'at the centre of the discourse.'⁴⁴¹

National SRHR and HIV strategic plans and frameworks

The National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019 acknowledges that adolescents living with disabilities often have unmet SRHR needs, primarily due to the lack of reasonable accommodations to facilitate access to SRH services.⁴⁴² It recommends that CSE should be developed using appropriate communication mediums for adolescents living with disabilities. The inadequacy of the document is that it would have been better served by incorporating more comprehensive information on the provision of reasonable accommodations for adolescents living with disabilities. For example, the National Strategic Plan for HIV, STIs and TB 2017-2022 is the only document that comprehensively identifies specific services for persons with disabilities, including peer-led or peer-supported outreach, specialised health education regarding risk and vulnerability to STIs, HIV, and TB, CSE, and access to prevention services, as well as universal design and reasonable accommodation.⁴⁴³

The She Conquers Campaign: Focus on Adolescent Girls and the Young Women 2016 briefly mentions persons with disabilities, but fails to address the challenges and the distinct

⁴³⁷ Y Hassabie 'Supported decision-making for persons with mental and/or intellectual disabilities: An examination of Ethiopia's legal and institutional framework in light of the CRPD' (2022) 6(1) *Ethiopian Journal of Human Rights* 82-108.

⁴³⁸ Art 12, CRPD.

⁴³⁹ Committee on the Rights of Persons with Disabilities Article 12: Equal recognition before the law General Comment 1 (2014) CRPD/C/GC/1.

⁴⁴⁰ As above.

⁴⁴¹ L Series & A Nilsson 'Article 12 CRPD: Equal recognition before the law' in I Bantekas, MA Stein, D Anastasiou (eds). *The UN Convention on the Rights of Persons with Disabilities: A commentary* (2018) 339-382.

⁴⁴² Republic of South Africa 'National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019' 2019, <https://srjc.org.za/wp-content/uploads/2019/10/02-National-Adolescent-Sexual-and-Reproductive-Health-and-Rights-Framework-Strategy-pdf-003.pdf> (accessed 19 May 2024).

⁴⁴³ Hanass-Hancock and others (n 75) 6.

needs of persons with disabilities.⁴⁴⁴ Similarly, the Department of Public Service and Administration Strategic Framework for Public Service HIV and AIDS Response 2012 neglects to consider the SRH needs of persons with disabilities.⁴⁴⁵ The Policy Framework to Address Gender-Based Violence in the Post-School Education and Training System 2020 considers that persons with disabilities are at a higher risk of GBV⁴⁴⁶ and encourages structured engagement for persons with disabilities, including peer education networks. However, it shows little consideration for persons with disabilities and cannot be considered disability inclusive.⁴⁴⁷

The National Strategic Plan on Gender-Based Violence and Femicide 2020 acknowledges that persons with disabilities are vulnerable to discrimination.⁴⁴⁸ Furthermore, it highlights the difficulties that persons with disabilities experience in accessing services, particularly healthcare and safety and protection services. Despite addressing certain aspects of disability inclusion, the document fails to address the SRH needs of persons with disabilities and their right to access SRHR services.

National disability policies or Acts and National Strategic Plans on disability

The South African White Paper on the Rights of Persons with Disabilities 2015 indirectly aligns to Article 25 CRPD, which recognises the right to access SRH services.⁴⁴⁹ The primary objective of the White Paper is to protect rights and the integrate persons with disabilities into mainstream society. In contrast, the Framework and Strategy on Disability and Rehabilitation Services 2015 is centred on delivering specialised services for disability or rehabilitation.⁴⁵⁰ Of particular concern is that the White Paper and the Framework and Strategy briefly mention SRHR without adequately linking it to existing SRHR policies and strategic frameworks.⁴⁵¹

⁴⁴⁴ Republic of South Africa 'She Conquers campaign: Focus on adolescent girls and young women' 2016, <https://www.childrenandaids.org/sites/default/files/2020-01/She%20Conquers%20Campaign%2C%20South%20Africa.pdf> (accessed 19 May 2024).

⁴⁴⁵ Department of Public Service and Administration 'A Strategic Framework for Public Service HIV & AIDS Response' 2012, <https://www.dpsa.gov.za/dpsa2g/documents/institutional/2010-2014%20DPSA%20Strategic%20Plan.pdf> (accessed 19 May 2024).

⁴⁴⁶ Department of Higher Education and Training 'Policy Framework to Address Gender-Based Violence in the Post-School Education and Training System' 2020, <https://www.dhet.gov.za/Social%20Inclusion/DHET%20GBV%20Policy%20Framework%2030July2020.pdf> (accessed 19 May 2024).

⁴⁴⁷ Hanass-Hancock and others (n 75) 6.

⁴⁴⁸ Republic of South Africa *National Strategic Plan on Gender-Based Violence and Femicide* (2020) Available at <https://www.justice.gov.za/vg/gbv/nsp-gbv-final-doc-04-05.pdf> (accessed 19 May 2024).

⁴⁴⁹ Hanass-Hancock and others (n 75) 9.

⁴⁵⁰ As above.

⁴⁵¹ As above, 10.

This shortcoming undermines the protection and promotion of SRHR, including access to related services and CSE.⁴⁵²

Linkage to international and national obligations

According to the report by Hanass-Hancock and others, the Policy of Sexual and Reproductive Health 2011-2021, the National Strategic Plan 2017-2022, the National Strategic Plan on Gender-Based Violence and Femicide 2020, and the 2019 National Contraception Clinical Guidelines align with the obligations of the CRPD, the Constitution and the White Paper on the Rights of Persons with Disabilities.⁴⁵³

As documented in the Sexual and Reproductive Health and Rights and Disability Policy Analysis Report 2021, the incomplete linkage between health and SRHR policies in South Africa is concerning.⁴⁵⁴ Hence, most health policies are being implemented in isolation with little or no consideration for persons with disabilities.⁴⁵⁵ The health policies that mention SRH but do not refer to elements of SRHR include the Adolescent and Youth Health Policy 2016 - 2020, Integrated School Health Policy, National HIV Testing Services: Policy 2016 and Sexually Transmitted Infections: Management Guidelines 2018.⁴⁵⁶ In contrast, the DBE National Policy on HIV, STI, and TB Policy, National Adolescent SRHR Framework Strategy, Policy on Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021, and the National Strategic Plan 2017-2022 make reference to SRH and SRHR.⁴⁵⁷

2.5 Conclusion

South Africa's legislation, policies, and programmes regarding the rights of persons with disabilities appear fragmented.⁴⁵⁸ In 2018, the South Africa Law Reform Commission received a request from the Department of Justice and Constitutional Development to investigate the non-adoption of the CRPD or the Optional Protocol into domestic law.⁴⁵⁹ Basson indicates that

⁴⁵² As above.

⁴⁵³ As above, 5.

⁴⁵⁴ As above, 9.

⁴⁵⁵ As above, 5.

⁴⁵⁶ As above.

⁴⁵⁷ As above.

⁴⁵⁸ Ngwenya and others (n 355) 3.

⁴⁵⁹ Art 12, ICESCR (n 344).

South Africa has failed to meet 4 out of 6 indicators from Articles 5 and 6 of the CPRD.⁴⁶⁰ In addition, Basson noted that South Africa has not submitted a country report on the status of CRPD implementation, signalling a lack of progress in implementing the Convention.⁴⁶¹

Kamga contends that the absence of a Disability Act in South Africa impedes the realisation of disability rights.⁴⁶² This perpetuates South Africa's lack of comprehensive disability legislation.⁴⁶³ The Sexual and Reproductive Health and Rights and Disability Policy Analysis Report 2021 reveals that the majority of SRHR policies and programmes overlook the needs of persons with disabilities in South Africa.⁴⁶⁴ Similarly, disability policies and programmes are not inclusive of SRHR.

Without a doubt, the promotion of inclusiveness is essential for dismantling barriers and facilitating the participation of persons with disabilities in SRHR programmes and everyday pursuits alongside their counterparts.⁴⁶⁵ The lack of disability inclusion in SRHR policies and strategies impedes access to SRH programmes, services, benefits, and opportunities.⁴⁶⁶ It is important to monitor and evaluate whether SRH programmes include persons with disabilities.⁴⁶⁷ This evaluation process will enable the identification of individuals benefitting from these services and reveal areas that require additional improvement.⁴⁶⁸

⁴⁶⁰ Y Basson 'Towards equality for women with disabilities in South Africa: The implementation of articles 5 and 6 of the Convention on the Rights of Persons with Disabilities' (2021) 9 *African Disability Rights Yearbook* 3-22.

⁴⁶¹ As above, 22.

⁴⁶² S D Kamga 'The national implementation and monitoring of the Convention on the Rights of Persons with Disabilities' in C Ngwenya and others (eds) *South Africa disability legislation and policy gap analysis* (2015) 182-204., <https://policycommons.net/artifacts/3759285/south-africa-disability-legislation-policy-gap-analysis/4564834> (accessed 15 May 2024).

⁴⁶³ TB van Reenen & H Combrinck 'The UN Convention on the Rights of Persons with Disabilities: Progress after 5 years' (2011) 8(1) *International Journal of Human Rights* 133-165.

⁴⁶⁴ Hanass-Hancock and others (n 75) 11.

⁴⁶⁵ Berger (n 198) 20.

⁴⁶⁶ As above, 21.

⁴⁶⁷ As above, 22.

⁴⁶⁸ As above.

Chapter 3. Scoping review methodology and findings and discussion

3.1 Introduction

This chapter presents the scoping review methodology employed to address the research questions. The methodology was useful to summarise the empirical research into persons with disabilities experiences of accessing SRH services at public sector healthcare settings in South Africa. Each stage of the scoping review is thoroughly documented to ensure transparency of the research process and dependability of the findings. In alignment with the Penchansky and Thomas framework of access, the findings of the qualitative literature are also reported in this chapter. A detailed discussion is undertaken informed by the findings of the scoping review.

3.2 Methods

The scoping review followed the Arksey and O'Malley framework and the recommendations suggested by Levac and others.⁴⁶⁹ The Arksey and O'Malley framework comprises the following stages: 1) formulating the research question; 2) searching for relevant studies; 3) selecting eligible studies; 4) charting the data; and 5) collating, summarising, and reporting the results. The recommendations put forth by Levac and others to advance the scoping review methodology include 1) forming a research team with expertise in both methodological and subject; 2) maintaining transparency in the decision-making process for selecting studies; 3) providing a clear description of the nature and details of data extraction; 4) developing a data charting form to ensure consistency in the data collected; 5) having two independent researchers to chart the data to increase the reliability of findings; and 6) systematically analysing, reporting and applying meaning to the findings to that ensure the results are accurately conveyed.⁴⁷⁰

⁴⁶⁹ D Levac and others 'Scoping studies: advancing the methodology' (2010) 69(5) *Implementation Science* 1-9.

⁴⁷⁰ As above, 3.

Stage 1: Identification of the review questions

The Population-Concept-Context (PCC) framework recommended by the Johanna Briggs Institute guided the research questions for this scoping review.⁴⁷¹ Table 6 outlines the population, concept, and context of the scoping review. The research questions also considered human rights and public health concerns related to the experiences of persons with disabilities with SRH services and the challenges they face in accessing them.

Table 6: Population, concept, and context of the proposed scoping review.

Population	Persons with disabilities (adolescents and adults, irrespective of gender)
Concept	Experiences of SRH services
Context	Public healthcare settings in South Africa

The following review questions were developed using the PCC framework in collaboration with a clinical SRH practitioner and a public health practitioner, serving as a guide for the scoping review:

1. How do persons with disabilities experience access to SRH services in public healthcare settings?
2. What are the challenges and barriers persons with disabilities experience in accessing SRH services?

Stage 2: Searching for relevant studies

The search strategy was developed in collaboration with an academic librarian from the University of Pretoria. Table 7 illustrates the search terms and keywords aligned to the PCC framework.

⁴⁷¹ The Joanna Briggs Institute 'The Joanna Briggs Institute Reviewers' Manual: Methodology for JBI Scoping Reviews' 2015, <https://reben.com.br/revista/wp-content/uploads/2020/10/Scoping.pdf> (accessed 19 May 2024)

Table 7: Search terms and keywords related to the PCC

Population	Concept		Context
Persons with disabilities	Experiences of sexual and reproductive health services		Public healthcare settings in South Africa
	Experiences	Sexual and reproductive health services	
Persons and disabilities	Perceptions	Sexual and reproductive health	South African public health settings
Persons with physical impairments	Views	Reproductive health	South African public health facilities
Persons with visual impairments	Attitudes of healthcare providers	Sexual health services	South Africa
Persons with hearing impairments	Prejudices	Reproductive health services	
Persons with intellectual impairments	Difficulties	Antenatal Care	
Persons with sensory impairment	Challenges	Postnatal care	
Persons with physical disabilities	Barriers	Contraceptives	
Persons with mental disabilities	Access	Abortion	
		Obstetric services	

In June 2024, a search for scholarly articles was conducted using Medline, CINAHL, PsycINFO, Elicit, and Web of Science, with a focus on publications from 1994 onward. The use of Boolean operators, including AND, OR, and NOT, was implemented to integrate the search terms and subsequently narrow the results. Additionally, a secondary search was carried

out on the reference lists of studies included in the analysis to identify any relevant additional studies.

Stage 3: Selecting eligible studies.

The eligibility criteria (inclusion/exclusion criteria) guided the study selection, as shown in Table 8.

Table 8: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Articles published in English	Articles not published in English.
Qualitative research studies (including those conducted as part of mixed methods research approach distinguishing the qualitative outcomes) on the experiences of persons with disabilities in accessing SRH services	Grey literature and quantitative studies
Studies reporting on the experiences of persons with disabilities accessing SRH services in South Africa	Studies that report the experiences of persons with disabilities in accessing SRH services outside South Africa.
	Articles published before 1994

The principal researcher (DG, MPhil candidate in the SRRA program) carried out the database search under the guidance of the research supervisor. Scoping reviews are typically not done independently due to the need to ensure their validity and reliability. As reported by Pollock and others, a team approach is necessary for rigorous evidence synthesis across the entire scoping review process, which encompasses data extraction, analysis, and presentation.⁴⁷² In light of these considerations, it was judged essential to collaborate with two experts in the fields of public health and community health studies, who served as reviewers. After exporting eligible references to Endnote 21, duplicates were identified and eliminated prior to screening. Both the principal researcher and the community health studies reviewer conducted independent title and abstract screening, with discrepancies being resolved through consultation with the public health reviewer to achieve consensus. The full-text screening process was carried out independently by the principal researcher and the community health

⁴⁷² D Pollock and others 'Recommendations for the extraction, analysis, and presentation of results in scoping reviews' (2023) 21(3) *JBIR Evidence Synthesis* 520-532.

studies reviewer. In instances where discrepancies arose during the screening process, the public health reviewer was consulted to resolve them. The reasons for excluding articles were documented and presented in a summary. To ensure transparency, a PRISMA flow diagram was employed to visually represent the summary of the search and screening processes (see Figure 7).

Stage 4: Data charting

Under the guidance of the research supervisor, the principal researcher created a data extraction template using Google Forms. The data was extracted, and then verified by the other reviewers. The data extraction form comprised several fields, which included the author/s, year of publication, purpose of the study, research site, study population (type of disability), demographics (age, gender), study design, data collection, data analysis, qualitative findings (quotations and authors interpretations), limitations of the study and recommendations.

Stage 5: Collating, summarising, and reporting the results

According to Pollock and others, qualitative synthesis approaches such as content analysis may be employed in scoping reviews to elucidate features or factors related to a concept.⁴⁷³ Content analysis can provide knowledge and insights about the research phenomenon.⁴⁷⁴ The Johanna Briggs Institute recommends the application of the Elo and Kyngas qualitative content analysis approach for scoping reviews.⁴⁷⁵ This approach comprises three phases, namely preparation, organisation, and reporting.⁴⁷⁶ The preparation phase commenced with the principal researcher determining if there was a need to conduct a qualitative content analysis during the development of the scoping review protocol. Additionally, the scoping review team was required to select whether the content analysis would be executed using an inductive or deductive method.⁴⁷⁷ The deductive approach was chosen, which typically involves aligning extracted data with a predetermined theoretical framework or model (Figure 6).⁴⁷⁸ The adapted version of the Panchansky and Thomas framework of access was selected as the deductive framework, which comprises the dimensions of availability, accessibility, acceptability, accommodation, affordability, awareness, and agency.⁴⁷⁹

⁴⁷³ As above, 522.

⁴⁷⁴ S Elo & H Kyngas 'The qualitative content analysis process' (2007) 62(1) *The Journal of Advanced Nursing* 107-115.

⁴⁷⁵ Pollock and others (n 472) 526.

⁴⁷⁶ Elo & Kyngas (n 474) 107.

⁴⁷⁷ As above, 109.

⁴⁷⁸ Pollock and others (n 472) 526.

⁴⁷⁹ Mitchell and others (n 321) 4.

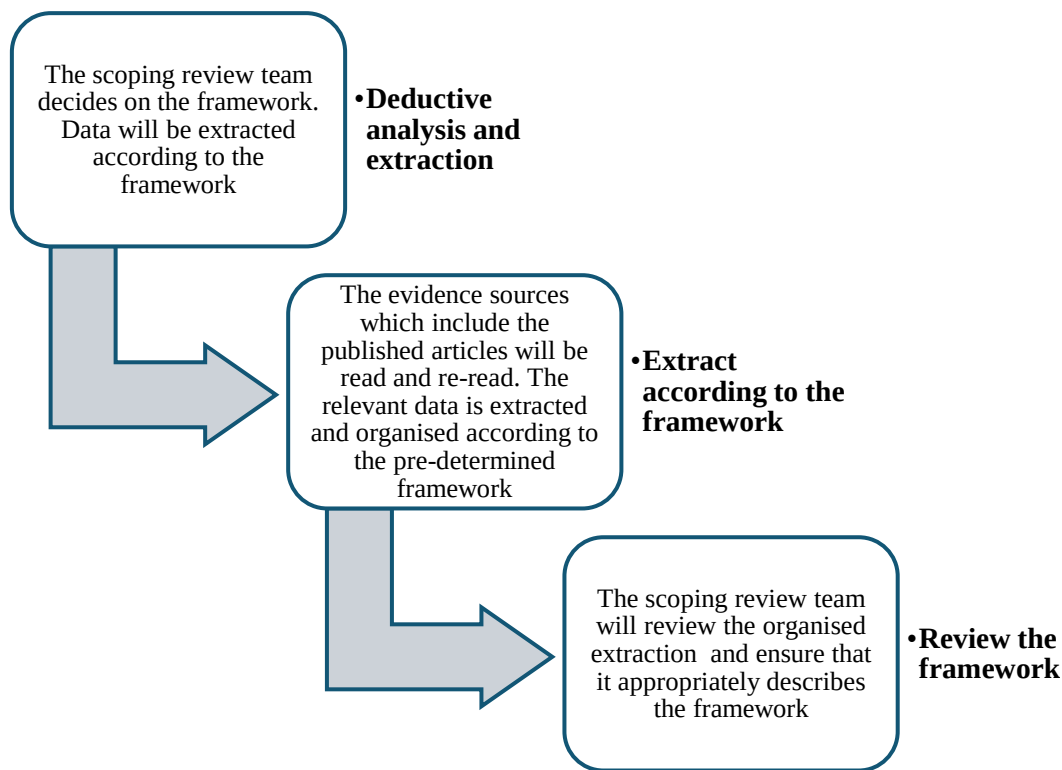


Figure 6: The deductive approach to analysing qualitative data within a scoping review, adapted from Pollock and others⁴⁸⁰

During the organising phase, the principal researcher and other reviewers read and re-read the journal articles to understand how the data is related to the objective and scoping review questions. The principal researcher extracted data according to the adapted version of the Penchansky and Thomas framework of access. The quotations and authors' interpretations were extracted verbatim from the results section and mapped to the dimensions of availability, accessibility, acceptability, accommodation, affordability, awareness, and agency. The principal researcher and the other reviewers forming the scoping review team deliberated and reviewed the extracted data to ensure that it accurately conveyed the interpretation of the

⁴⁸⁰ Pollock and others (n 472) 526.

framework. The research supervisor was also consulted for guidance on the deductive qualitative content analysis approach.

The results of the content analysis were reported systematically and logically according to the dimensions of the Penchansky and Thomas theory of access. Verbatim quotes are included in the reporting to enhance the credibility of the data extracted by demonstrating transparency and providing thick descriptions of the research phenomenon.⁴⁸¹

3.3 Results

Search results and study selection

As illustrated in Figure 7, 1186 records were retrieved across the five databases. Following the removal of 130 duplicates, 1056 articles were available for screening. Sixteen articles were subjected to a full-text evaluation, and five of these articles satisfied the inclusion criteria.

General characteristics of the study

The general characteristics of the included studies are described in Table 9. All the included studies were published between 2015 and 2024. The age range of participants across the studies varied from 13-49 years old. Three of the five studies analysed were conducted in KwaZulu-Natal. The five studies encompassed a diverse range of disabilities among participants, including hearing impairments, visual impairments, and physical impairments. Of the five studies, four studies used in-depth interviews for data collection and one study used focus group discussions.

⁴⁸¹ AK Shenton 'Strategies for ensuring trustworthiness in qualitative research projects' (2004) 22 *Education for Information* 63-75.

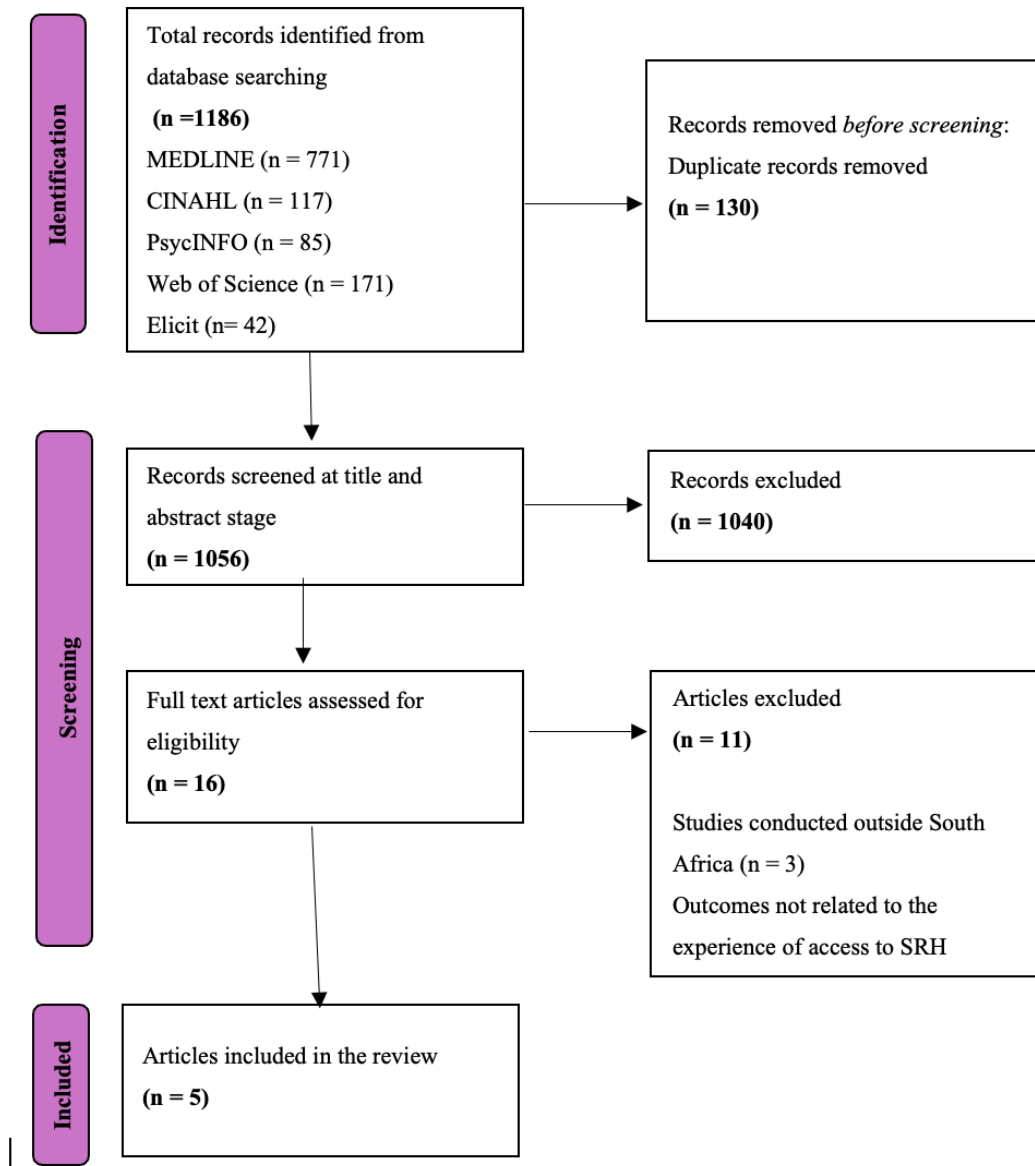


Figure 7: PRISMA flowchart of the study selection process

Table 9: Characteristics of the studies

Author (year of publication)	Title	Region in South Africa	Study aim/objective	Participants sample size, gender, age range	Type of disabilities	Data collection and analysis
Gichane and others (2017)	“They must understand we are people”: Pregnancy and maternity service use among signing Deaf women in Cape Town.	Western Cape	To describe the experiences of pregnancy, utilisation of maternity services, and pregnancy outcomes of deaf women who communicate through sign language.	42 women with disabilities All participants were of reproductive age 18-49 years of age.	Hearing	In-depth interviews Thematic Analysis
Mathabela and others (2024)	Exploring Barriers to Accessing Sexual and Reproductive Health Services among Adolescents and Young People with Physical Disabilities in South Africa	Mpumalanga	To explore the barriers faced by adolescents and young people with disabilities to accessing sexual and reproductive health services in clinical settings.	27 adolescents and young people with disabilities 11 females 16 males 13 -24 years of age	Physical	Focus Group Discussions Thematic Analysis
Mavuso & Maharaj (2017)	Reproductive health barriers facing men and	KwaZulu-Natal	To explore the barriers confronting persons with disabilities in gaining access to	16 persons with disabilities	Physical Visual	In-depth interviews

Author (year of publication)	Title	Region in South Africa	Study aim/objective	Participants sample size, gender, age range	Type of disabilities	Data collection and analysis
	women with disabilities in Durban, South Africa		reproductive healthcare services.	6 males 10 females 27-46 years of age		Thematic analysis
Mavuso & Maharaj (2015)	Access to sexual and reproductive health services: Experiences and perspectives of persons with disabilities in Durban, South Africa	KwaZulu-Natal	To comprehend the experiences and perspectives of persons with disabilities regarding their access to sexual and reproductive health services.	16 persons with disabilities 6 males 10 females 27-46 years of age	Physical Visual	In-depth interviews Thematic Analysis
Mheta and others (2023)	Experiences of women with disabilities in Accessing Maternal Healthcare Services: A South African Case Study	KwaZulu-Natal	The objectives were two-fold. Firstly, to report the experiences of women with disabilities in accessing maternal healthcare services during pregnancy, childbirth and post-partum care. Secondly to explore the	12 women with disabilities All participants were of reproductive age 18 -45 years of age	Physical Hearing Visual	In-depth interviews Framework Analysis

Author (year of publication)	Title	Region in South Africa	Study aim/objective	Participants sample size, gender, age range	Type of disabilities	Data collection and analysis
			barriers to maternal healthcare services for women with disabilities			

Persons with disabilities experiences and challenges to accessing SRH services

The findings related to the experiences, challenges and barriers to accessing SRH services are presented in Table 10, under the dimensions of availability, accessibility, acceptability, accommodation, affordability, awareness, and agency.

Table 10 Findings from the deductive analysis according to the dimensions of the adapted Penchansky and Thomas framework of access

Dimension	Findings from the deductive analysis
<i>Availability</i>	The unavailability of skilled HCPs proficient in sign language constitutes a barrier to accessing maternal healthcare services.
<i>Accessibility</i>	Poor access to public transportation.
	Health facilities offering SRH services are often situated in areas which render them inaccessible.
	The subspecialty maternal health services at higher levels of care are situated at a greater distance.
	Lack of social support hinders the ability to access SRH services.
<i>Accommodation</i>	Facilities often have narrow corridors, narrow entrances, stairs and a lack of ramps, which do not accommodate persons with disabilities.
	Lack of appropriate equipment to accommodate persons with disabilities during SRH consultations.
	Sign language interpreters are unavailable in healthcare facilities to enable access to SRH services.
	SRH information is not available in alternative formats for persons with disabilities.
	The hours of operation are inconvenient at facilities.
	Long queues at health facilities results in a longer waiting period for SRH services.
	There is a lack of tailored SRH information for persons with disabilities.

Dimension	Findings from the deductive analysis
<i>Affordability</i>	Additional costs are incurred by women with disabilities when travelling to tertiary institutions for subspeciality maternal health services.
	The hiring of metered taxis to attend SRH consultations increases the costs of accessing SRH services.
	Additional expenses are incurred by persons with disabilities when they are compelled to return the following day to consult with a healthcare provider who was unavailable on the initial visit or when the clinic service hours had concluded.
	Additional expenses for transportation are incurred by persons with disabilities who need a family member or friend to accompany them to a healthcare facility for assistance and support.
	Lack of finances due to unemployment.
<i>Acceptability</i>	Perceived stigma and discrimination.
	SRH services are not disability inclusive.
	Encounters of disrespect and unfriendliness.
	Communication difficulties with HCPs.
	Family influence.
<i>Awareness</i>	Lack of SRH information.
	Lack of education, explanations and communication regarding SRH by HCPs.
	Lack of awareness about the need for antenatal care.
<i>Agency</i>	HCPs do not respect and uphold the SRH autonomy of persons with disabilities.
	Infringement on the right to dignity.

Dimension	Findings from the deductive analysis
	Women with disabilities experience undue influence from HCPs to terminate their pregnancy or undergo sterilisation without receiving counselling.

Availability

Studies such as that conducted by Mheta and others⁴⁸² and Gichane and others⁴⁸³ have shown that unavailability of skilled HCPs proficient in sign language constitutes a barrier to accessing maternal healthcare services. This observation aligns with the accounts of one participant who lamented that nurses stated, “We cannot communicate with the deaf, you must come with a person”.⁴⁸⁴ Moreover, the absence of sign language education among HCPs impacts on the quality of maternal health services and leaves women with disabilities feeling discontented.⁴⁸⁵ The same sentiment was voiced by a signing deaf participant in the Western Cape study, who shared, “Also, while I was in labor the nurse was speaking with me but I could not understand. So, I keep the pain to myself”.⁴⁸⁶

Accessibility

The scoping review revealed that the accessibility barriers faced by persons with disabilities include poor access to public transport, the geographic location of health facilities offering SRH services, subspeciality maternity services at higher levels of care are situated at a greater distance, and lack of social support. According to Mavuso and Maharaj, most persons with disabilities are dependent on public transportation to access SRH services.⁴⁸⁷ A participant reported on her experiences by stating, “It is difficult because from here I have to walk to X street to get a taxi to the clinic because there is no transport that comes to this side, but coming back is even more difficult because there is no transport from there to here”.⁴⁸⁸ The participant

⁴⁸² D Mheta and others ‘Experiences of women with disabilities in accessing maternal healthcare services: A South African case study’ (2023) 20 *International Journal of Environmental Research and Public Health* 1-13.

⁴⁸³ MW Gichane and others ‘They must understand we are people: Pregnancy and maternity service use among signing deaf women in Cape Town’ (2017) 10 *Disability and Health Journal* 434-439.

⁴⁸⁴ Mheta and others (n 482) 6.

⁴⁸⁵ Gichane and others (n 483) 434.

⁴⁸⁶ As above.

⁴⁸⁷ S Mavuso & P Maharaj ‘Access to sexual and reproductive health services: Experiences and perspectives of persons with disabilities in Durban, South Africa’ (2015) 29(2) *Agenda* 78-88.

⁴⁸⁸ As above, 85.

went on to describe that she occasionally had to walk on foot, a challenging and arduous task for a pregnant individual with a disability.⁴⁸⁹ Women with disabilities have expressed that despite health facilities being accessible via public transport, they face difficulties accessing public transport due to its distance from their homes.⁴⁹⁰ On the opposite side of the spectrum, some participants reported that healthcare facilities offering SRH services are frequently located in geographically hard-to-reach areas.⁴⁹¹

Mheta and others indicated that women with disabilities facing high-risk pregnancies may be referred to subspecialty maternity services at higher levels of care.⁴⁹² However, these services are often located at a greater distance, making it a challenge for women with disabilities to find their own transportation to access these services.⁴⁹³

Persons with disabilities experience a lack of social support which hinders accessibility to SRH services.⁴⁹⁴ According to a participant, “At times if you want to attend a clinic and tell your mother about the clinic, then she will be against the idea to an extent that she will discourage you going to the clinic”.⁴⁹⁵ The scoping review revealed persons with disabilities who did not have someone to accompany them to the health facility were unable access SRH services independently.⁴⁹⁶

Accommodation

The studies included in the scoping review all identified accommodation-related challenges and barriers. Participants cited infrastructure barriers comprising narrow corridors, entrances, stairs, and the absence of ramps.⁴⁹⁷ One wheelchair user shared, “My wheelchair, it could not fit in the consultation room”⁴⁹⁸ while a visually impaired participant said, “The hospital has so many stairs and it is difficult for me as I am visually impaired”.⁴⁹⁹

⁴⁸⁹ As above.

⁴⁹⁰ Mheta and others (n 482) 9.

⁴⁹¹ S Mavuso & P Maharaj ‘Reproductive health barriers facing men and women with disabilities in Durban, South Africa’ (2017) 15 (3) *Gender & Behaviour* 9468-9482.

⁴⁹² Mheta and others (n 482) 7.

⁴⁹³ As above, 9.

⁴⁹⁴ Mathabela and others (n 86) 8; Mavuso & Maharaj (n 491) 9476.

⁴⁹⁵ Mathabela and others (n 86) 9; Mavuso & Maharaj (n 487) 85.

⁴⁹⁶ Mheta and others (n 482) 8; Mayuso & Maharaj (n 491) 9476.

⁴⁹⁷ Mheta and others (n 482) 7.

⁴⁹⁸ As above.

⁴⁹⁹ As above.

The studies also identified a lack of appropriate equipment to accommodate persons with disabilities during SRH consultations.⁵⁰⁰ Women with disabilities encountered difficulties with non-adjustable examination couches and beds, bathrooms without rails and the absence of disability-friendly weighing scales.⁵⁰¹ For example, one participant said, “Because I have one leg, it was difficult for me to climb onto the bed. I had to be assisted by the nurses... they had to physically carry me”.⁵⁰² Another participant shared, “They did not weigh me. They would do the other check-ups but because I could not stand on the scale, I was never weighed”⁵⁰³

Persons with disabilities using wheelchairs said that condoms were placed in hard-to-reach locations. As per a participant’s personal account, “If you are in a wheelchair and you want to get some condoms, you will find that they are up there and then as a result, you will have to say sorry sister, can you please give me a packet of condoms”.⁵⁰⁴

The findings also suggest that the lack of sign language interpreters in healthcare facilities is a significant barrier for persons with disabilities accessing SRH services.⁵⁰⁵ As one participant urged, “Please, please, please, we need interpreters...there are no interpreters and also in clinics there’re no interpreters”.⁵⁰⁶ The absence of information on SRH in alternative formats for persons with disabilities was highlighted in the interview data collected by Mheta and others⁵⁰⁷ and Mavuso and Maharaj.⁵⁰⁸ A participant with visual impairment stated, “At the antenatal class, they had pictures and used actions to explain to us how we breastfeed our kids. I could not see anything.”⁵⁰⁹ According to Mavuso and Maharaj’s findings, persons with visual impairments expressed concern that information regarding SRH is not accessible in alternative formats such as braille, enlarged print, or audio compact disks.⁵¹⁰

Operating hours of the public healthcare facilities were noted as a barrier for persons with disabilities accessing SRH services. Participants said that if they arrived at the clinic late, they encountered long queues and excessive waiting times.⁵¹¹ Occasionally, the clinic would

⁵⁰⁰ Mheta and others (n 482) 7; Mavuso & Maharaj (n 487) 86; Mavuso & Maharaj (n 491) 9477.

⁵⁰¹ Mheta and others (n 482) 7.

⁵⁰² As above.

⁵⁰³ As above.

⁵⁰⁴ Mavuso & Maharaj (n 491) 9477.

⁵⁰⁵ Gichane and others (n 483) 438; Mheta and others (n 482) 8.

⁵⁰⁶ Mheta and others (n 482) 6.

⁵⁰⁷ As above.

⁵⁰⁸ Mavuso & Maharaj (n 491) 9473.

⁵⁰⁹ Mheta and others (n 482) 6.

⁵¹⁰ Mavuso & Maharaj (n 487) 82.

⁵¹¹ Mavuso & Maharaj (n 491) 9476.

close before they could receive SRH services, and nurses instructed them to return the following day.⁵¹²

Adolescents and young people with disabilities expressed concern that SRH information is not tailored for their needs.⁵¹³ As one pointed out, “Information on reproductive health is not directed towards us”.⁵¹⁴ To further illustrate that the SRH information needs of persons with disabilities are not being met, another expressed, “On my case as a young man, people think that information on reproductive health is not for us”.⁵¹⁵

Affordability

The burden of additional expenses related to accessing SRH services was a concern in three studies. SRH services, including maternal healthcare, are provided without charge at public sector health facilities. However, persons with disabilities often incur transportation and other indirect costs when accessing these services.⁵¹⁶ Transportation expenses were perceived as a significant hardship by persons with disabilities, as many of them were unemployed and reliant on state disability benefits.⁵¹⁷ Women with disabilities experiencing high risk pregnancies incurred a substantial increase in transportation costs when they needed to travel to higher level facilities for subspeciality maternal healthcare services.⁵¹⁸ Persons with disabilities reported that they were confronted with substantial transportation expenses when difficulties with accessing public transport compelled them to hire metered taxis to take them to health facilities to access SRH services.⁵¹⁹

Additional expenses for persons with disabilities worsen when nurses instruct them to return the following day to consult with a healthcare provider that was unavailable on the initial visit or when the clinic service hours had concluded.⁵²⁰ Moreover, persons with disabilities often incur additional expenses when they require the accompaniment of a family member or friend to a healthcare facility for assistance and support during SRH consultations.⁵²¹ One participant shared, “On occasion, they inform you that they are not currently open and advise you to return the next day. The expense is considerable since you are responsible for covering

⁵¹² Mathabela and others (n 86) 7.

⁵¹³ As above.

⁵¹⁴ As above.

⁵¹⁵ As above.

⁵¹⁶ Mheta and others (n 482) 9.

⁵¹⁷ Mavuso & Maharaj (n 487) 86.

⁵¹⁸ Mheta and others (n 482) 9.

⁵¹⁹ Mavuso & Maharaj (n 487) 85.

⁵²⁰ As above.

⁵²¹ Mheta and others (n 482) 9.

the cost of the person accompanying you as well”.⁵²² In another example, a participant stated, “As I am blind and have one leg when I need to go to the clinic for post-natal care, I need someone to accompany me to carry the baby for me. This means I need transport fees for two people”.⁵²³

Acceptability

Barriers to acceptability included perceived stigma and discrimination, SRH services are not disability inclusive, encounters of disrespect and unfriendliness, communication difficulties with HCPs, family influence, and fear of judgement. Persons with disabilities reported that they experienced stigma and discrimination while accessing SRH services at public health facilities.⁵²⁴ Persons with disabilities often report feeling that HCPs treat them differently from individuals without disabilities, particularly in the way care is delivered at healthcare facilities.⁵²⁵ For example, a participant with hearing impairment narrated the following, “I felt the nurses were ignoring me maybe because I’m deaf and they were attending the hearing patients... They gave the hearing women fair treatment, but they were ignoring me because of my deafness”.⁵²⁶ Another participant with physical impairments described the following encounter, “They ask, what do you want here, we want people who are walking here. They wouldn’t want to deal with disabled individual”.⁵²⁷

Stigma towards persons with disabilities was reflected in the negative stereotypes or misconceptions that HCPs showed about disability. According to persons with disabilities, HCPs assume that they are asexual with dysfunctional reproductive systems.⁵²⁸ A participant communicated her concerns about stigma in the following statement: “It surprises the healthcare workers that we get pregnant. It’s like we do not have functional reproductive systems.”⁵²⁹ The misconception that persons with disabilities are asexual and cannot bear children is also supported in the following quote, “At Hospital X, I felt that the medical staff

⁵²² Mavuso & Maharaj (n 487) 85.

⁵²³ Mheta and others (n 482) 8.

⁵²⁴ Mathabela and others (n 86) 11; Mheta and others (n 482) 9; Mavuso & Maharaj (n 487) 83; Mavuso & Maharaj (n 491) 9476.

⁵²⁵ Mathabela and others (n 86) 11; Mheta and others (n 482) 8.

⁵²⁶ Mheta and others (n 482) 8.

⁵²⁷ Mathabela and others (n 86) 11.

⁵²⁸ As above; Mheta and others (n 482) 6.

⁵²⁹ Mheta and others (n 482) 6.

did not acknowledge that I am capable of having children, and they persistently inquired about it in a derogatory manner.”⁵³⁰

Women with disabilities interviewed by Mavuso and Maharaj reported that HCPs were surprised that they were sexual beings and needed family planning services.⁵³¹ For instance, one participant reported the following encounter with HCPs, “When you come to the clinic, and tell them I am here for family planning, they jump and say What? She wants family planning! Does she have a man? You see that is the problem. They react with shock”.⁵³² Persons with disabilities have also been inappropriately characterised as hypersexual by HCPs.⁵³³ As another participant noted, “Nurses were saying I love men too much, that is why I keep getting pregnant.”⁵³⁴

Persons with disabilities have reported experiences where HCPs have made them feel inferior about their bodies and sexual needs.⁵³⁵ A study participant with a physical impairment narrated an incident in which nurses had mocked her, asking, "Being like this, how do you sleep with a man?"⁵³⁶ The studies found that persons with disabilities experienced ridicule from HCPs about their sexuality.⁵³⁷ One such instance is illustrated by the following quote: “Who will want to be in love and accept you are. . . you don't have any other life except this one of disability, and you can't have a boyfriend”.⁵³⁸

Persons with disabilities interviewed in all the studies argued that SRH services were not disability inclusive. Yet there is a strong need for disability inclusive maternity services by persons with disabilities: “The healthcare workers need to be sensitised on how to be disability-inclusive in the provision of maternal healthcare services”.⁵³⁹ Moreover, persons with disabilities reported incidents of disrespect and unfriendliness from HCPs. Specifically, women with disabilities cited that nurses would disregard their pleas for assistance and frequently spoke to them in a raised voice.⁵⁴⁰ Another participant recounted the following distressing encounter, stating, “In hospital where I delivered my baby, they ignored me and said “you will deliver on your own and keep on crying like that.”⁵⁴¹ This insensitivity towards the challenges

⁵³⁰ As above, 7.

⁵³¹ Mavuso & Maharaj (n 487) 84.

⁵³² As above.

⁵³³ Mheta and others (n 482) 7.

⁵³⁴ As above, 8.

⁵³⁵ Mathabela and others (n 86) 6; Mavuso & Maharaj (n 487) 84.

⁵³⁶ Mavuso & Maharaj (n 487) 84.

⁵³⁷ Mathabela and others (n 86) 12; Mavuso & Maharaj (n 491) 9475.

⁵³⁸ Mathabela and others (n 86) 12.

⁵³⁹ Mheta and others (n 482) 7.

⁵⁴⁰ Mheta and others (n 482) 7; Mavuso & Maharaj (n 487) 84.

⁵⁴¹ Mheta and others (n 482) 8.

experienced by persons with disabilities is exemplified in the following statement, “I went to a clinic, and there was another nurse there. She instructed me to remove my clothing. I informed her that it was challenging for me. In response, she inquired, ‘Who will assist you? Why don't you teach yourself to remove your clothes?’”⁵⁴² Persons with disabilities reportedly encountered instances where HCPs posed intrusive enquiries about their sexuality which were perceived as offensive and disrespectful.⁵⁴³

Persons with disabilities experienced communication difficulties with healthcare workers due to the lack of sign language skills, stigma and discrimination,⁵⁴⁴ as shared by one participant, “When I arrive at the clinic, at times I want to talk to nurses about reproductive health issue. But, you see, nurses are difficult to talk to. They talk to you with attitude because some of them don't care”.⁵⁴⁵ Discrimination negatively impacts the communication between persons with disabilities and HCPs. A participant's statement underscores this point: “We do want information, but nurses show us bad attitudes, treat us bad as in we are not human enough it is very difficult for us to go seek information at the clinic. The way they respond to our questions one sees that we are not welcome you can see their expression is different from able bodied patients.”⁵⁴⁶

Family members' attitudes can also impact the acceptability of SRH services for persons with disabilities.⁵⁴⁷ One participant shared, “At times if you want to attend a clinic and tell your mother about the clinic, then she will be against the idea to an extent that she will discourage you to the clinic.”⁵⁴⁸ Persons with disabilities feared what others would think of them accessing and utilising SRH services.⁵⁴⁹ One participant echoed his fear of being judged, stating, “It is very difficult to access sexual and reproductive services because we have a fear of what other people are going to say or think of us.”⁵⁵⁰

Awareness

Participants in the study acknowledged that they had not received adequate education on SRH from family members and health facilities. They reported feeling marginalised in terms of

⁵⁴² Mathabela and others (n 86) 10.

⁵⁴³ Mavuso & Maharaj (n 491) 9475.

⁵⁴⁴ Gichane and others (n 483) 437; Mheta and others (n 482) 8.

⁵⁴⁵ Mathabela and others (n 86) 11

⁵⁴⁶ As above.

⁵⁴⁷ As above, 8.

⁵⁴⁸ As above, 9.

⁵⁴⁹ As above. See also Mavuso & Maharaj (n 487) 83.

⁵⁵⁰ Mathabela and others (n 86) 8.

accessing information about SRH.⁵⁵¹ According to women with disabilities, they were uninformed about the fact that menstruation signalled the onset of puberty, as well as the possibility of pregnancy resulting from sexual intercourse during this stage of development.⁵⁵² As one participant stated, “When you start your menstrual period, you are not told that you are now entering puberty and you can fall pregnant at any time. When I fell pregnant it was like I have killed 100 people”.⁵⁵³

Gichane and others found that women with disabilities generally lacked awareness of the importance of antenatal care, which led to the majority of them initiating antenatal visits only by the third trimester.⁵⁵⁴ Persons with disabilities reportedly encountered situations in which HCPs failed to offer sufficient SRH education and explanations in response to their inquiries about SRH.⁵⁵⁵ One participant shared, "On occasion, when we request information from nurses, we have encountered instances of being ignored or denied such information, or having our questions go unanswered."⁵⁵⁶ Women with disabilities reported that they did not receive counselling on family planning options and were reprimanded if they inquired about contraceptives.⁵⁵⁷ These unfavourable experiences deterred women with disabilities from seeking SRH services.⁵⁵⁸

Agency

Mavuso and Maharaj found that HCPs do not respect and uphold the SRH autonomy of persons with disabilities.⁵⁵⁹ Women with disabilities reported encounters whereby HCPs had advised them to terminate their pregnancies or sterilise without the appropriate counselling.⁵⁶⁰ One participant shared her experience, “When I went to the hospital and they discovered that I was two months’ pregnant with this child, my last born, they said I must terminate the pregnancy because I am blind. A nurse tells you to just go to that side and make an appointment to do an abortion. The nurses said the pregnancy will create problems for you, and also you are causing problems for your family”.⁵⁶¹ In another example, nurses at a clinic asked one participant,

⁵⁵¹ As above, 5. See also Mavuso & Maharaj (n 487) 82.

⁵⁵² Mavuso & Maharaj (n 487) 82.

⁵⁵³ As above.

⁵⁵⁴ Gichane and others (n 483) 437.

⁵⁵⁵ Mathabela and others (n 86) 5; Mavuso & Maharaj (n 491) 9475.

⁵⁵⁶ Mathabela and others (n 86) 5.

⁵⁵⁷ Mavuso & Maharaj (n 491) 9475.

⁵⁵⁸ As above.

⁵⁵⁹ Mavuso & Maharaj (n 487) 87.

⁵⁶⁰ As above.

⁵⁶¹ As above, 84.

“Why you do not sterilise?”⁵⁶² These experiences shared by women with disabilities convey that their right to dignity have been infringed.⁵⁶³

3.4 Discussion

The scoping review aimed to map literature regarding the experiences of persons with disabilities in accessing SRH services, considering the challenges and barriers they encounter at public healthcare facilities in South Africa. Guided by the Penchansky and Thomas framework of access, the reviewed studies identified that SRH services, information, and health facilities are not fully inclusive and accessible to persons with disabilities.⁵⁶⁴ A drawback of all the reviewed studies is the lack of detailed exploration of availability of SRH services (family planning, contraception, maternal and perinatal health, fertility care, prevention and treatment of STIs and HIV, abortion and post-abortion care) and resources (SRH providers, contraceptives). However, the unavailability of HCPs proficient in sign language is an important finding as it hinders persons with disabilities access to quality SRH services. Despite HCPs lack of sign language proficiency, the healthcare facilities did not provide sign language interpreters for individuals with hearing impairments, which created a barrier to effective communication. Research by Kumi-Kyereme and others⁵⁶⁵ and Mprah and others⁵⁶⁶ in Ghana similarly identified the unavailability of sign language interpreters and trained HCPs in sign language as a significant barrier to accessing SRH services for those with hearing impairments. This scoping review illustrated that SRH information in alternative formats such a braille, enlarged print and audio was unavailable for persons with disabilities in South Africa. Studies reporting on the availability of SRH in alternative formats for persons with disabilities is rare to find in the literature which demonstrates the lack of disability inclusiveness in SRH services.

Accessibility is critical in both Penchansky and Thomas’s framework of access and the right to health framework.⁵⁶⁷ The framework of access views accessibility as the ease with which persons with disabilities can physically reach a health facility.⁵⁶⁸ The barriers to

⁵⁶² As above.

⁵⁶³ As above, 86.

⁵⁶⁴ Mheta and others (n 482) 12; Mavuso & Maharaj (n 487) 86.

⁵⁶⁵ A Kumi-Kyereme and others ‘Factors contributing to challenges in accessing sexual and reproductive health services among young people with disabilities in Ghana’ (2021) 8 *Global Social Welfare* 189-198.

⁵⁶⁶ WK Mprah and others ‘Barriers to the utilisation of sexual and reproductive health services among young deaf persons in Ghana’ (2022) 26(12) *African Journal of Reproductive Health* 58-66.

⁵⁶⁷ General Comment 14 (n 328) para 21.

⁵⁶⁸ CG McLaughlin & L Wyszewianski ‘Access to care: Remembering old lessons’ (2002) 37(6) *Health Services Research* 1441-1443.

accessibility that were identified included public transportation, the geographic location of healthcare facilities, the distances to subspecialty maternal services, and the lack of social support. Similarly, Shiwakoti and others found that women with disabilities in Nepal were unable to access SRH services if they did not have a family member or friend to accompany them to the health facilities.⁵⁶⁹ The struggles to access public transportation to health facilities were also observed by Seidu and others⁵⁷⁰ and Ahumuza and others.⁵⁷¹ The barriers related to accommodation, which include disability unfriendly infrastructure and equipment, inconvenient hours of operation, long queues and waiting times, and the lack of disability inclusive SRH information, were also observed in Ghana,⁵⁷² Senegal,⁵⁷³ and Uganda.⁵⁷⁴ Barriers impeding access to health infrastructure, buildings and SRH information infringes on the right to SRH.

The findings of this review indicate that persons with disabilities experience financial challenges to access SRH services. These relate to the indirect costs associated with the use of private transportation services, transport costs for escorts to health facilities, and additional transportation costs to visiting higher levels of care. These out-of-pocket costs are consistent with findings of past studies by Seidu and others⁵⁷⁵ and Soule and Sonko.⁵⁷⁶ Affordability is an important dimension that can lead to persons with disabilities not accessing and receiving SRH services and information. The scoping review demonstrates that while SRH services are free at public sector institutions, there are hidden costs associated with accessing them.

Persons with disabilities experienced stigma and discrimination which hinders their access to SRH services. The asexuality narrative about persons with disabilities facilitates their exclusion from SRH services. Ahumuza and others found that discrimination leads to marginalisation in SRH service provision for persons with disabilities, aligning with the findings of this review.⁵⁷⁷ A study in Nepal revealed that persons with disabilities perceived discrimination from HCPs as a major barrier to disability inclusive SRH services.⁵⁷⁸ The reports of unfriendliness and disrespect from HCPs negatively impacted on the acceptability of

⁵⁶⁹ R Shiwakoti and others 'Factors affecting utilization of sexual and reproductive health services among women with disabilities - A mixed-method cross-sectional study from Ilam district, Nepal' (2021) 21 *BMC Health Serv Research* 1-19.

⁵⁷⁰ Seidu and others (n 222) 11.

⁵⁷¹ Ahumuza and others (n 245) 6.

⁵⁷² Seidu and others (n 222) 12.

⁵⁷³ O Soule & D Sonko 'Examining access to sexual and reproductive health services and information for young women with disabilities in Senegal: A qualitative study' (2022) 30 (1) *Reproductive Health Matters* 494-508.

⁵⁷⁴ Ahumuza and others (n 245) 4.

⁵⁷⁵ Seidu and others (n 222) 12.

⁵⁷⁶ Soule & Sonko (n 573) 499.

⁵⁷⁷ Ahumuza and others (n 245) 6.

⁵⁷⁸ Shiwakoti and others (n 569) 12.

SRH services. Other studies have also demonstrated the negative impact of family influence, and the fear of judgement on the SRH seeking behaviours of persons with disabilities.⁵⁷⁹

Awareness encapsulates not only knowledge on the existence of SRH services but also health literacy. Persons with disabilities frequently lack access to information when HCPs fail to offer them appropriate health education. Furthermore, there are instances where HCPs fail to capitalise on opportunities to impart SRH education to persons with disabilities. This is exemplified by their tendency to withhold explanations for SRH-related inquiries, thereby depriving persons with disabilities of vital information. The lack of SRH information for persons with disabilities is consistent with other studies in Senegal⁵⁸⁰ and Uganda⁵⁸¹ Shiwakoti and others argues that access to information promotes awareness of SRH.⁵⁸²

In the context of agency, persons with disabilities not only encountered the denial of SRH information, but their reproductive autonomy was also disregarded by HCPs, who urged them to undergo sterilisation or terminate their pregnancies. These findings perpetuate the notion that persons with disabilities are incapable of parenting. It is indisputable that persons with disabilities confront challenges in terms of being stripped their decision-making powers to reproduce and establish a family.

In a nutshell, this scoping review highlights that the experience of access to SRH services by persons with disabilities is shaped by the challenges and barriers they encounter in public healthcare settings. These same challenges and barriers have been identified in regional and international literature. Women with disabilities have reportedly faced more discriminatory treatment from healthcare providers than men with disabilities. This presents a glaring instance of multiple discrimination on account of gender and disability. The findings of the scoping review are concerning because the realisation of SDGs is dependent on the inclusion of persons with disabilities. The SDGs were designed to align with human rights obligations and work towards ensuring SRHR of all individuals. Gruskin and others argue that unaddressed rights contribute to the formation of barriers that hinder access to SRH services.⁵⁸³ Hence, promoting SRHR for all and elimination of barriers to access necessitates collective focus to structures, systems, and rights.⁵⁸⁴

⁵⁷⁹ Ahumuza and others (n 245) 6; Seidu and others (n 222) 12; Soule & Sonko (n 573) 500.

⁵⁸⁰ Soule & Sonko (n 573) 498.

⁵⁸¹ Ahumuza and others (n 245) 6.

⁵⁸² Shiwakoti and others (n 569) 11.

⁵⁸³ S Gruskin and others 'Inclusion of human rights in sexual and reproductive health programming: Facilitators and barriers to implementation' (2021) 16(10) *Global Public Health* 1559-1575.

⁵⁸⁴ Gruskin and others (n 583) 1569.

The scoping review has notable limitations. Despite a thorough literature search, only five articles were available, highlighting the scarcity of research on persons with disabilities and their access to SRH services in South Africa. The limitation of the review to English language articles also presents a problem of selection bias. Furthermore, grey literature was excluded, which could have omitted potentially rich information. Notwithstanding these limitations, significant findings were yielded on the experiences of persons with disabilities accessing SRH services at public healthcare facilities in South Africa.

3.5 Conclusion

This chapter describes how persons with disabilities experience access to SRH services and the challenges they encounter at public healthcare settings in South Africa through a scoping review of qualitative studies. The evidence affirms that there is an urgent need to recognise and protect the SRHR of persons with disabilities. The recommendations emanating from the study findings will be discussed in Chapter 4.

Chapter 4. Conclusion and recommendations

4.1 Conclusion

This study explored how the right to SRH intersects with the experiences of persons with disabilities as they access SRH services in public healthcare facilities. The study also examined South Africa's human rights obligations and the extent to which disability is included in existing policies and frameworks. Based on the evidence reviewed in Chapter 2, the majority of SRHR policies and programmes fail to consider the needs of persons with disabilities.

The scoping review has shown that persons with disabilities experience structural, system and rights explicit barriers to accessing SRH services at public health facilities in South Africa. Structural and system barriers include the lack of trained HCPs in sign language, the unavailability of sign language interpreters, geographic constraints of health facilities, disability unfriendly infrastructure, and lack of adaptable equipment. The rights explicit barriers include stigma and discrimination, deprivation of SRH information, lack of respect for agency and autonomy. The inadequacy of disability-friendly infrastructure and accessible equipment underscores the failure to meet the reasonable accommodation and universal design requirements established by the CRPD, thereby hindering the promotion of disability inclusiveness in healthcare facilities that provide SRH services. Consequently, the failure to address SRHR can create barriers to access. This study demonstrates that the right to SRH is intricately linked to the experience of accessing SRH services.

4.2 Recommendations

Recommendations emerged from the evaluation of South Africa's SRHR policies and framework, including the findings from the scoping review. There is an urgent need to cultivate a culture of inclusivity by employing a rights-based and social approach to disability with the objective of removing the barriers that impede persons with disabilities from accessing SRH services. SRH policies and frameworks must address disability inclusiveness. Hanass-Hancock and others recommend audits on all SRHR policies and frameworks to improve disability inclusion.⁵⁸⁵ It is critical to align national laws and policies with regional and global

⁵⁸⁵ Hanass-Hancock and others (n 75) 11.

commitments to improve the SRHR of persons with disabilities. By drawing on human rights obligations, states must respect, protect and fulfil the SRHR of persons with disabilities. In light of human rights obligations and this study's findings, it is imperative that the South African government implement necessary measures to eliminate barriers created by individuals, communities, and institutions that impede access to SRH services for persons with disabilities.

There is a significant role for civil society advocates to play in terms of holding the government to account as a duty bearer for its obligations to persons with disabilities as rightsholders under international and regional law. Advocacy around health financing is critical to ensure adequate budget allocation for commitments under international, regional and national instruments.

HCPs and persons with disabilities must be brought together for training on disability inclusive SRHR. In addition, Persons with disabilities must be included and represented on the health facility committees. Mavuso and Maharaj recommend that persons with disabilities must participate in the development and implementation of disability inclusive SRH programmes.⁵⁸⁶

Mheta and others suggest that the DoH employ the WHO Disability Inclusive Health Services Toolkit and Training Package to train maternal healthcare providers in disability inclusive maternal health services.⁵⁸⁷ Stigma and discrimination which undermines the sexual and reproductive autonomy of persons with disabilities can be mitigated through social and behavioural change communication. Stereotypes such as the notion that persons with disabilities are asexual and incapable of reproducing must be dispelled by fostering dialogue about sexuality of persons with disabilities within communities and healthcare settings. Sensitising HCPs on the experiences of persons with disabilities in accessing SRH information and services can enhance disability inclusion in the provision of healthcare.

SRH information must be disability inclusive and provided in accessible formats to ensure that persons with disabilities maintain agency and autonomy over their SRH. Gichane and others stress that sign language interpretation for women with hearing impairments is essential to guarantee quality healthcare services per the AAAQ framework.⁵⁸⁸ The DoH Disability and Rehabilitation Directorate should regularly assess health facilities to ensure the infrastructure is disability friendly. Universal design and reasonable accommodation must be

⁵⁸⁶ Mavuso and Maharaj (n 491) 9480.

⁵⁸⁷ Mheta and others (n 482) 10.

⁵⁸⁸ Gichane and others (n 483) 438.

provided as means to achieve disability inclusiveness and upholding the commitments of the CPRD.

There is a necessity for additional research in South Africa to provide information for the development of disability inclusive SRH policies and services.

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