



UNFPA

Situational Analysis: Access to Sexual and Reproductive Health and Rights (SRHR) for Young Persons with Disabilities in East and Southern Africa

KPMG Services Proprietary Limited
October 2017
Situational Analysis

Acronyms

Afriyan	African Youth and Adolescent Network on Population and Development
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral treatment
CWD	Children with disabilities
CSE	Comprehensive sexuality education
DHS	Development and Health Surveys
DFID	Department of International Development
DPO	Disabled People's Organisation
EAC	East African Community
eMTCT	Elimination of Mother to Child Transmission
EAC	East African Community
ESA	East and Southern Africa
FP 2020	Family Planning 2020 (global programme)
HCT	HIV Counselling and Testing
ICF	International Classification of Function
LGBTI	Lesbian, gay, bi-sexual, transgender, intersex
NGO	Non-Governmental Organisation
OECD	Organisation of Economic Cooperation and Development
PMTCT	Prevention of mother-to-child transmission
PremDESA	Preventing Maternal Deaths in East and Southern Africa
PEP	Post-exposure prophylaxis

PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PWD	Persons with disabilities
SANAC	South African National AIDS Council
SIDA	Swedish International Development Corporation
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
UNCRC	United Nations Convention on the Rights of a Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
YFS	Youth friendly services
YPWD	Young Persons with Disabilities
WHO	World Health Organisation

List of figures

Figure 1 Regional strategy in context of global and regional agendas	10
Figure 2: Strategy development approach.....	12
Figure 3: Top three disabilities at country level (number of countries that rank the disability in the top three most prevalent disabilities)	19
Figure 4: Socio-ecological approach to access to SRHR by young persons with disabilities. 35	
Figure 5: The Six Building Blocks of a Health System	47
Figure 6: WHO Pillar Framework of Analysis	49
Figure 7: Integrating the WHO pillar and socio-ecological models and examples of the necessary response	53

List of Tables

Table 1: Prevalence of disabilities (all ages) across East and Southern African countries in order of reported magnitude	18
Table 2: SRHR services.....	22
Table 3: Key development partners for SRHR and young persons with disabilities	37
Table 4: The Pillars of the Framework of Analysis for young persons with disabilities Access to SRHR.....	50
Table 5: Activities and indicators related to young persons with disabilities and SRHR.....	56
Table 6: National Disability Frameworks	59
Table 7: Regional SRHR legal and policy frameworks	76
Table 8: National SRHR frameworks, policies and plans	77
Table 9: Ministry responsibility for young persons with disabilities	92
Table 10: Civil society coordinating bodies and 'umbrella' organisations	93
Table 11: National governance structures for young persons with disabilities.....	94
Table 12: Development partner budgets.....	101
Table 13: Disability-specific reports generated from census data.....	110
Table 14: SRHR services.....	125
Table 15: Estimated number of vaccinated females and human papillomavirus vaccine coverage in Africa by October, 2014.....	127

Contents

1	Executive Summary	1
2	Background	8
3	Introduction	11
3.1	About the regional strategy	11
3.2	About the situational analysis	12
4	Part 1 – Literature Review	14
4.1	Disabilities	14
4.2	Sexual Reproductive Health and Rights	20
4.3	“Intersectionality” of age, gender, disability and other factors in the context of SRHR	28
4.4	Socio-ecological view of access to SRHR	34
4.5	ESA SRHR and young persons with disabilities development partners	36
5	Part 2 – Situational analysis	47
5.1	Framework of analysis	47
5.2	Legal and policy framework	54
5.3	Leadership and governance structures	91
5.4	Funding	99
5.5	Workforce	104
5.6	Knowledge management	108
5.7	Products, technology and commodities	112
5.8	Service delivery and programmes	116
6	References	133

1 Executive Summary

Accessing sexual and reproductive health and rights (SRHR) services introduce challenges for many persons regardless of who they are or where they come from. However, for young persons with disabilities access to SRHR services is particularly challenging.

Young persons with disabilities become sexually active and experience their sexuality as early and as often as young people without disabilities.¹ Therefore, young persons with disabilities require access to SRHR services and education in the same manner that young people without disabilities do. Enabling young persons with disabilities to realise their SRHR, such as the delay of pregnancy and prevention of infection, in turn helps to ensure other rights are realised, such as the right to education, economic opportunities, financial independence, and social empowerment.² Conversely, the increased risk of violence, negligence, sexual abuse, discrimination and denial of rights faced by persons with disabilities means that provision of SRHR services and education is essential for young persons with disabilities.³

The 2006 United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) is the first binding human rights convention which establishes that human rights and fundamental freedoms apply to all persons with disabilities. The Convention creates obligations for member states to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.”⁴ Specifically, the Convention recognises the SRHR of young persons with disabilities. It does this within a context of a number of obligations to member states to, inter alia:

- Eliminate discrimination against persons with disabilities relating to marriage, family, parenthood and relationships, including recognition of the rights of persons with disabilities who are of marriageable age to marry and to found a family;
- Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons (including SRHR);
- Recognise the diversity of persons with disabilities and different needs of persons with different impairments;
- Ensure that multiple sectors, including health, education and justice sectors and their workforces, are sufficiently trained on the needs of persons with disabilities and their rights under the Convention;

¹ UNFPA, 2015

² UNFPA, 2013

³ Brown, H, 2010

⁴ UNCRPD, 2006, p3

- Recognise that equal access to services includes considering accessibility to the physical, social, economic and cultural environment, and to information and communication;
- Emphasise the importance of mainstreaming disability issues as an integral part of relevant strategies to ensure sustainable development; and
- Recognise the valued contributions made by persons with disabilities to society and the potential for enhanced participation in a nation's human, social and economic development.⁵

In addition, the Convention of the Rights of the Child and the Special Rapporteur on the Right to Health have strongly affirmed the importance of SRHR for young persons and have called on states to take a host of specific measures to ensure the full realisation of these rights.⁶

UNFPA intends to develop regional strategic guidance ('the guidance') to increase access to SRHR services for young persons with disabilities in ESA. The services of KPMG have been engaged to support the development of the guidance.

This situational analysis has been developed as an interim deliverable in the process to develop the regional guidance. The situational analysis is a working document throughout the life-cycle of the project to develop the guidance. This version of the situational analysis was developed based on desktop research from 23 ESA countries and regional level data. It was further supplemented with information provided by stakeholders who attended two regional validation meetings. The first meeting was held on 30 November – 2 December 2016 and the second meeting was held from 19-21 September 2017. Following the second meeting, the situational analysis was finalized for the purposes of this engagement.

The situational analysis will be used to inform the development of the guidance and can be used as a source of information thereafter, during the implementation of the guidance.

The purpose of the situational analysis is to:

- Provide insight into the current situation of young persons with disabilities and their access to SRHR in the region; including the legislative environment in which they exist and how it supports or hinders this;
- Document existing efforts to address young persons with disabilities' access to SRHR; including through comprehensive sexuality education (CSE) and social and behaviour change communication (SBCC); the organisations leading these efforts, relevant materials and as evidence of best practices;
- Identify research priorities to inform the regional guidance; and
- Make recommendations for the development of the regional guidance.

⁵ UNCRPD, 2006

⁶ Centre for Reproductive Rights, 2017

The situational analysis attempts to determine how the intersection of youth and disability contributes to the challenge of accessing SRHR. It also considers how being female affects access to SRHR and whether women and girls with disabilities are disproportionately affected by the challenges to access SRHR services and education. The situational analysis is structured in two parts:

- The first part describes the existing literature surrounding the major topics in this situational analysis – young people with disabilities, access to sexual and reproductive healthcare and rights and the intersectionality of these, and the key stakeholders or development partners in the region with a focus on SRHR and young persons with disabilities.
- The second part analyses young persons with disabilities' access to SRHR services based on a framework derived from the World Health Organisation's (WHO) six pillars of a well-functioning healthcare system. An additional pillar representing the legal and policy framework response has been added. Therefore, the seven pillars of analysis include: legal and policy framework; leadership and governance structures; funding; workforce; knowledge management, products, technology and commodities; and service delivery and programmes.

The emerging findings from the situational analysis against each of the pillars of an effective healthcare system are summarised below:

Legal and policy framework

Legislative and policy frameworks are important as they provide enforceable direction and requirements for programming and service delivery.⁷ Across the 23 ESA countries there are a range of legal and policy documents which contribute to the legal framework surrounding young persons with disabilities and their access to SRHR. There are, however, no legal and policy documents which address the intersection of SRHR and young persons with disabilities. Rather, the legal framework provides for persons with disabilities, SRHR and youth separately.

International and regional frameworks provide a good basis for national legislation and policy-making. More recently, possibly arising as an outcome of the ESA Commitment, governments appear to be recognising and integrating SRHR of youth into national policies. However, further specific focus on young persons with disabilities is required to ensure their unique needs are met.

Leadership and governance structures

Leadership and governance structures play an important role in ensuring young persons with disabilities have access to SRHR services. Leadership is a broad concept which can include political will, public will, advocacy and communication. It also spans political, religious,

⁷ WHO, 2017

business and civil society spheres. Leadership and governance structures are particularly important given that the needs of young persons with disabilities and issues of SRHR are both often misunderstood and marginalized and require a strong voice to advocate for the importance and needs of both.

In recent years there has been increasing political support for comprehensive sexuality education (CSE) among ESA governments.⁸ However, responsibility for young persons, including young persons with disabilities, and their SRHR needs is a multi-sectoral consideration, involving health, education, youth and social welfare ministries in government. While many ESA countries have governance bodies to coordinate the activities of government departments, civil society and development partners, very little information is publically available on the mandate, terms of reference or effectiveness of such structures.

There are increasing efforts to include youth in political, economic and social processes and structures. Specifically, young persons with disabilities are represented by the African Youth with Disabilities Network (AYWDN), which has chapters in nine ESA countries.

Funding

In order to achieve their intended objectives, regional and national strategies related to increasing access to SRHR by young persons with disabilities must be costed and funded. Determining the amount or source of current funding for SRHR services or programmes for young persons with disabilities is very difficult. Funding comes from government, multi- and bi-lateral donor agencies, international non-governmental organisations (NGOs), civil society and other sources.

In recent years, government funding for HIV in ESA has increased considerably. However many countries remain reliant on donor funding from international or private funders which can have repercussions for the sustainability of their HIV response.

Workforce

Workforce refers to the service providers, professionals, employees and volunteers responsible for providing SRHR information and services. SRHR service providers include healthcare providers, community caregivers, social workers, CSE teachers and traditional healers among others. The workforce plays an essential role in ensuring access to good quality SRHR.

There are a number of challenges in SRHR workforces across ESA, including insufficient numbers of healthcare providers, inadequate training or skills, and cultural and personal attitudes. The issues related to workforce described in this sector are all exacerbated by the intersectionality of young persons with disabilities, SRHR, age and gender. Both SRHR and disabilities are commonly misunderstood across the ESA region and health care providers

⁸ UNESCO, 2016

are no exception to the cultural attitudes and perceptions that impact the ability of young persons with disabilities to access services, particularly SRHR.

Knowledge management

Knowledge management is an essential component of any effective guidance for social change in order to understand the context of the situation, to direct and refine initiatives to enhance their effectiveness and efficiency and to ensure lessons are learned and programme and service delivery is based on evidence of what works.

Across the region, information and research regarding SRHR for persons with disabilities, and in particular young persons with disabilities, is severely lacking. The burden of the HIV epidemic experienced by ESA countries has provided a platform for intensive research on HIV and SRHR issues. However, to date, information on disabilities, and specifically young persons with disabilities, has been considered a gap among many countries in the region as it is not seen as a priority.

Strengthening the knowledge management of SRHR for young persons with disabilities has the potential to contribute towards more effective planning, more appropriate policy making in ESA countries and ultimately improved outcomes for young persons with disabilities.

Products, technologies and commodities

Assistive devices play a significant role in improving the quality and dignity of life for persons with disabilities.⁹ Appropriate assistive devices and technologies can benefit young persons with disabilities by rectifying, compensating for or alleviating the limitations they experience and help young persons with disabilities to be independent and empowered.¹⁰ Assistive devices and technologies help ensure young persons with disabilities can access SRHR services in a number of ways, for example, independently of a caregiver.

While government in ESA countries is typically responsible for providing certain basic healthcare and/or funding for such healthcare, it is difficult to identify data on the provision of or spending on assistive devices and technologies for persons with disabilities or young persons with disabilities.

Access to SRHR products and commodities is instrumental to promoting good SRHR. However young people often have limited access to quality SRHR product and commodities.¹¹ More so, young persons with disabilities are more vulnerable to social, economic and civic discrimination, as described previously.¹² This often means that young

⁹ UN, 1993

¹⁰ National Dissemination Center for Children with Disabilities, 2012

¹¹ Kassa et al., 2016

¹² Kassa et al., 2016

persons with disabilities experience additional limitations when it comes to accessing sexual and reproductive health products and commodities.

Service delivery and programmes

The design of services and programmes is important to ensure the intended results and impact set out by legislation, policies and strategies are achieved.

The UNCRPD sets out a number of obligations for member states related to the design and provision of services and programmes for persons with disabilities, including universal design, whereby programmes and services should be usable by all people, to the extent possible, without the need for adaptation or specialized design.¹³

Programmes and services first need to ensure understanding and knowledge of SRHR by young persons with disabilities. Comprehensive sexuality education (CSE) remains the main initiative in the region to provide this knowledge, however, given that young persons with disabilities are less likely to attend school than young persons without disabilities, provision must also be made to reach those persons. Within school-based CSE, materials must be suitable and accessible for young persons with disabilities and teachers must have relevant support and training on the needs of young persons with disabilities with respect to SRHR.

The UNCRPD obligates member states to take appropriate measures to ensure persons with disabilities have access, on an equal basis with others, to the physical environment, transportation, and other facilities and services open or provided to the public, both in urban and in rural areas.¹⁴

The Convention requires member states to ensure that service providers (including public and private) provide “reasonable accommodation” for persons with disabilities. Reasonable accommodation means undertaking necessary and appropriate modifications and adjustments to facilities, which do not impose a disproportionate or undue burden on the service provider, in order to ensure that persons with disabilities can access the facility on an equal basis to persons without disabilities.¹⁵ However, the physical accessibility of services remains a barrier to access for many young persons with disabilities in the region, particularly those in rural areas who also lack access to affordable transport to reach facilities.¹⁶ Communication is also a challenge including language and written print methods of communication and provision of information.

Accessing SRHR services, which is already intimidating for many, is even more challenging because of the added potential for moral, religious and cultural norms to influence perceptions, even within the service provider workforce. These attitudes can deter young persons generally from accessing SRHR services. Social and behaviour change communication (SBCC) methods are therefore important in strategies of advocacy, social

¹³ UNCRPD, 2006, p4

¹⁴ UNCRPD, 2006, p8

¹⁵ UNCRPD, 2006, p4

¹⁶ WHO, 2011 and UNFPA, 2016

and behaviour change communications for communities, families, individuals and service providers.

One of the other factors contributing to the limited support and health information for people with disabilities is the fact that in part, persons with disabilities and young persons with disabilities have not been included in the design and development of services provided to communities and thus their service requirements are not well articulated.¹⁷ A key obligation of the UNCRPD is that service and programme design is based on consultation with young persons with disabilities.

Closing

This situational analysis has highlighted that while there is significant evidence that young persons with disabilities have significant challenges in accessing SRHR services for a wealth of reasons. It also highlights that there are very few initiatives to try address these issues. So long as these challenges, experienced by some 18 million people across Africa continue to be prevalent – the rights of these individuals continue to be violated.

¹⁷ UNAIDS, 2014

2 Background

This section describes the mandate of the United Nations Population Fund (UNFPA) and other key stakeholders related to young persons with disabilities and SRHR, and key programmes and initiatives underway by UNFPA in support of young persons with disabilities and access to SRHR.

About UNFPA

UNFPA is an international development agency that promotes a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled, including young people with disabilities.

UNFPA East and Southern Africa Regional Office (ESARO), in partnership with other UN agencies, civil society organizations, the East African Community (EAC), the Intergovernmental Authority on Development (IGAD), the Common Market for Eastern and Southern Africa (COMESA) and the Southern African Development Community (SADC), promotes comprehensive adolescent sexual and reproductive health including HIV prevention, with the aim of harmonizing the legal and policy environment within all ESA countries to protect the SRHR of adolescents and young people.

UNFPA drives and supports a number of initiatives in the region to support the protection of SRHR of adolescents and young people. This includes the ESA Commitment on Comprehensive Sexuality Education (CSE) and Youth Friendly Services (YFS) for Adolescents and Young People. Ministers of Health and Education from 20 ESA countries adopted the ESA Commitment in 2013 to help ensure increased national level commitment and programming for young people in the ESA region. The ESA Commitment also responds to Africa's Agenda 2063 and the regional push to achieve the 'demographic dividend' by investing in the health, education, and employment of adolescents and young people in the region.

UNFPA programmes

UNFPA ESARO has embarked on, through DFID funding, a project called Preventing Maternal Deaths in East and Southern Africa (PreMDESAs). PreMDESAs is a two year regional project intended to contribute to the achievement of universal access to sexual and reproductive health care services and reduce maternal mortality in ESA.

The project outcomes are: 1) an increase in robust evidence relating to SRHR; and 2) the improved awareness of, access to and uptake of family planning and SRHR services across the ESA region, with a focus on women and adolescent girls. The PreMDESAs programme includes contraceptive provision and capacity building, innovation, knowledge sharing, research, and advocacy. The project brings a focus on SRHR for young people with

disabilities, a diverse, complex, marginalized and underserved population. The challenges faced by young persons with disabilities and the violations they experience when accessing SRHR make them a particularly vulnerable group.

UNFPA also partners with a number of organisations to provide WE DECIDE: a Programme for Equal Opportunities and a Life Free of Violence for young persons with disabilities. WE DECIDE promotes the human rights and social inclusion of adolescents and young persons with disabilities.¹⁸ The programme aims to:

- Gather evidence and data on the situation of young persons with disabilities;
- Create a platform for cooperation and exchange of ideas that promotes rights, social inclusion and equal opportunities;
- Empower young persons with disabilities through addressing participation and gender equality;
- Advocate to end violence, in particular sexual violence;
- Implement standards that address sexual violence and access to sexual and reproductive health and rights; and
- Promote social inclusion and equal opportunities for employment through engaging the private sector.¹⁹

Regional strategic guidance to increase access to SRHR services for young persons with disabilities

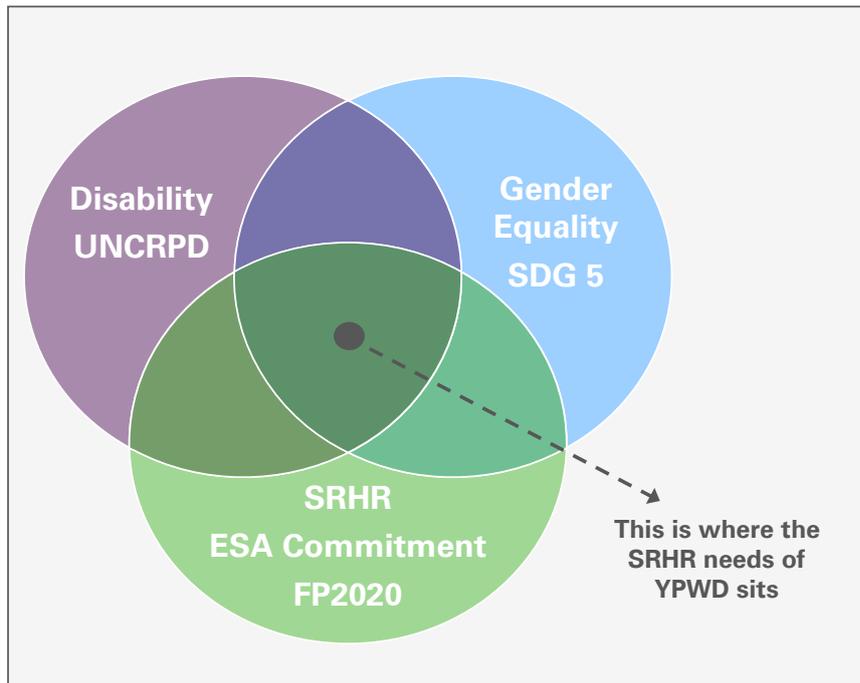
In line with these efforts to improve access to SRHR for young people, and in particular that of young persons with disabilities, UNFPA with the support of the United Kingdom Department of International Development (DFID), has commissioned the development of a regional strategic guidance to increase access to SRHR services for young persons with disabilities.

This work sits at the intersection of a number of important global agendas, namely: the disability agenda, promulgated in the UN Convention on the Rights of Persons with Disabilities; the SRHR agenda, supported globally through the FP 2020 initiative and in the region through the ESA commitment to improve access to SRHR; and sustainable development goal 5 which seeks to eliminate discrimination against women and girls. The regional guidance to improve access to SRHR by young persons with disability sits within the intersection of these agendas, as illustrated below.

¹⁸ Capasso, A., 2016

¹⁹ Management Sciences for Health, 2017

Figure 1 Regional strategic guidance in context of global and regional agendas



3 Introduction

This section describes the scope and approach to develop the regional guidance to improve access to SRHR for young persons with disabilities in ESA; and the objectives and approach to developing the situational analysis.

3.1 About the regional strategic guidance

UNFPA has commissioned the development of a regional strategic guidance ('the guidance') to increase access to SRHR services for young persons with disabilities in ESA. The services of KPMG have been engaged to support the development of the guidance.

The guidance intends to provide a coordinated direction and approach for UNFPA and its partners in the region in increasing access to SRHR services by young persons with disabilities. The guidance should take into consideration existing efforts to address the challenges facing young persons with disabilities in their access to SRHR; it should consider the wide ranging variations in the lived experience of young persons with disabilities; the social context in which young persons with disabilities attempt to access SRHR services and importantly it should be developed based on evidence.

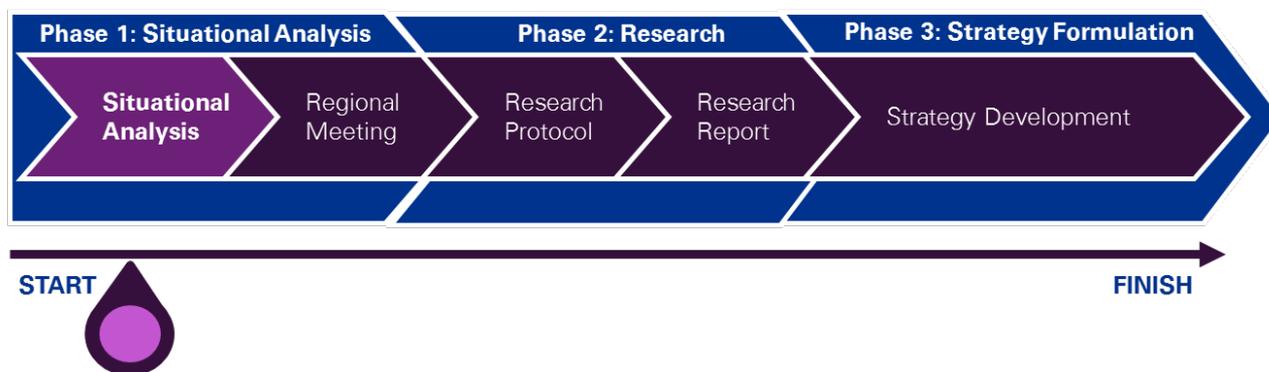
In order to address these requirements, the approach to developing the guidance is a series of interrelated activities described as follows:

1. Conduct a desktop situational analysis of SRHR among young persons with disabilities in the ESA region.
2. Conduct a consultative regional meeting with stakeholders from ESA countries to validate results of situational analysis, identify research priorities and make recommendations for development of the strategy.
3. Conduct research in four countries²⁰ to further inform the situational analysis; and document best practices and recommendations for the strategy development. Importantly, the research allows for the voices of young persons with disabilities to be reflected in the development of the strategy.
4. Support the formulation of a regional strategy for increasing access to SRH services for young people living with disabilities.

²⁰ While it was the intention to conduct research in four countries, in-country challenges meant that research was only conducted in South Africa during the timeframes required for this engagement. It is anticipated that the research will be completed at a later stage.

The approach to the development of the guidance is illustrated below

Figure 2: Guidance development approach



3.2 About the situational analysis

3.2.1 Purpose

The situational analysis intends to provide a high-level analysis of the current state of access to SRHR services by young persons with disabilities across the ESA region. The analysis provides the basis for strategic planning and development of the regional guidance.

The purpose of the situational analysis is to:

- Provide insight into the current situation of young persons with disabilities and their access to SRHR in the region, including the legislative environment in which they exist and how it supports or hinders this;
- Document existing efforts to address young persons with disabilities' access to SRHR, including through comprehensive sexuality education (CSE) and social and behaviour change communication (SBCC), the organisations leading these efforts, relevant materials and evidence of promising practices;
- Identify research priorities to inform the regional guidance; and
- Make recommendations for the development of the regional guidance.

In particular, the situational analysis attempts to determine how the intersection of age, disability and gender contributes to the challenge of accessing SRHR. It also considers how being female affects access to SRHR and whether women and girls are disproportionately affected by the challenges to access SRHR services and education. The situational analysis is structured in two parts:

- The first part describes the existing literature, data and definitions surrounding the major topics in this situational analysis – young persons with disabilities, access to SRHR and the intersectionality of these, and the key stakeholders or development partners in the region with a focus on SRHR and young persons with disabilities.
- The second part analyses young persons with disabilities' access to SRHR services based on a framework derived from the WHO's six pillars of a good healthcare system. These pillars are: legal and policy frameworks; leadership and governance structures; funding; workforce; knowledge management, products, technology and commodities; service delivery and programmes.

3.2.2 **Scope and approach**

An analysis of the current state of access to SRHR by young persons with disabilities across the ESA region is significant in scope. It incorporates 23 unique countries with different situations and contexts. Access to SRHR encompasses considerations related to legislation, policy, governance, workforce, funding, research and information, products, services and programmes across several sectors in each country, including health, education and justice.

Based on the project terms of reference, the situational analysis was a desk-based research exercise based on publically available material. Where academic journals were publically available, they were included but subscription-based academic journal sites were not accessed.

The situational analysis was developed based on desktop research from country and regional level data. The first version of the situational analysis was presented to stakeholders at the regional stakeholder meeting on 30 November – 2 December 2016. The second version included feedback from this meeting and additional research based on feedback provided by UNFPA. Feedback on the second version was provided by a South African-based expert on young persons with disabilities. The third version was provided to stakeholders at a second regional meeting held 19-21 September 2017. Thereafter, final revisions were made and the situational analysis was considered final for purposes of this engagement.

This situational analysis therefore provides a high level analysis of the common trends or themes that were identified across the region and which should provide a starting point and direction for regional planning. The real value from the situational analysis lies in understanding country-specific situations. It is intended that each country will take the learnings and regional trends provided in this document to develop their own country-specific situational analysis to explore in more depth and detail the specific context from which to design and plan national interventions to increase access to SRHR by young persons with disabilities. Four countries – Kenya, Malawi, South Africa and Uganda – are underway with this process currently.

x

4 Part 1 – Literature Review

Young persons with disabilities become sexually active and experience their sexuality as early and as often as young people without disabilities.²¹ Therefore, young persons with disabilities require access to SRHR services and education in the same manner that young people without disabilities do. In fact, the increased risk of sexual abuse, faced by persons with disabilities means that provision of SRHR services and education is essential for young persons with disabilities.²²

Various factors, including cultural barriers, stigma, capacity and attitudes of healthcare workers amongst others, mean that access to SRHR services and education can be challenging for any person - even more so for young persons with disabilities. The type and nature of the person's disability also affects the person's need for and access to SRHR services. In addition, the experience of a young person accessing such services, regardless of disability, exacerbates the challenges to access of SRHR. Gender also impacts access.

This section provides a review of the information available on disability and SRHR, including definitions and data on prevalence. It also attempts to explore the intersectionality of various factors which impact on young persons with disabilities access to SRHR. This section has been termed the 'literature review'. However, as the situational analysis is a desktop based exercise, supplemented by feedback from UNFPA workshop participants, the literature also informs the analysis in Part 2.

4.1 Disabilities

This section provides the definition of disability and persons with disabilities used for the situational analysis and the data on disability prevalence and types in the ESA region.

4.1.1 Definition of disabilities

Disability is an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. Persons with disabilities are defined as 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.²³

The United Nations Enable offers the following definition of disability:

²¹ UNFPA, 2016

²² Brown, H, 2010

²³ UNCRPD, 2006

“‘Disability’ results from the interaction between persons with impairments, conditions or illnesses and the environmental and attitudinal barriers they face. Such impairments, conditions or illnesses may be permanent, temporary, intermittent or imputed, and include those that are physical, sensory, psychosocial, neurological, medical or intellectual.”²⁴

Disability is therefore more than an individual’s health, physical or mental wellbeing issue and constructed through contextual factors (social and structural) that hinder a person with impairment to participate fully on an equal basis with others. According to Article 1 of the UNCRPD:

“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.”²⁵

For the purposes of this document, the definition of persons with disabilities, as defined by the UNCRPD, (above) will be adopted.

The challenges experienced by persons with disabilities are more complex than for persons without disabilities due to multidimensional factors influencing their experiences. The contextual complexity of disability therefore needs to be approached with a balance of consideration for bio-medical as well as psychological, social and structural factors.²⁶

The World Health Organisation (WHO) uses the International Classification of Function (ICF) to measure functioning at both an individual and population level. The ICF takes into consideration individual functioning, as well as contextual factors influencing an individual. The ICF (2001) provides the following ways of understanding disability:

Individual functioning:

- *Body Functions and Structures— describes actual anatomy and physiology/psychology of the human body; including include mental, sensory and pain, voice and speech, cardiovascular, haematological, immunological and respiratory; digestive, metabolic and endocrine; genitourinary and reproductive; neuromusculoskeletal and movement related; skin and related structures.*
- *Activity and Participation— describes the person’s functional status, including communication, mobility, interpersonal interactions, self-care, learning, and applying knowledge.*

Contextual Factors:

²⁴ UN Enable, 2006

²⁵ UNCRPD, 2006

²⁶ WHO, 2012

- *Environmental Factors*— factors that are not within the person's control, such as family, work, government agencies, laws, and cultural beliefs
- *Personal Factors*— include race, gender, age, educational level, coping styles, etc. Personal factors are not specifically coded in the ICF because of the wide variability among cultures. They are included in the framework, however, because although they are independent of the health condition they may have an influence on how a person functions

(ICF, 2001).

Young persons with disabilities

The situational analysis focuses specifically on young persons with disabilities. Young people are defined by UNDESA as persons aged 10-24 years.²⁷

4.1.2 Prevalence of Disabilities

This section considers the prevalence of disabilities globally, and across Africa and the ESA region. A common challenge in understanding and comparing disability data is the different definitions and measures of disability used. This makes comparison and analysis difficult across a wide range of data sources. This situational analysis does not attempt to compare or analyse prevalence data, instead this section is intended to provide the reader with an indicative understanding of the available data as a basis for engaging with the broader situational analysis and subsequent regional guidance.

Global

Nearly one billion people, or 15% of the world's population, currently live with some form of disability. Of these people, 2-4% experience significant difficulties in functioning.²⁸ This translates to one in seven people worldwide, or one in four households containing a person with a disability.

The prevalence of disability increases with increasing age. An estimated 180-220 million adolescents and young people aged 10-24 have a disability.²⁹(The corresponding prevalence is not known.)

Generally women are more likely to report disability than men. There are wide ranging estimates on difference in global prevalence of disability between men and women. While the Global Burden of Disease report estimates that women are about 11% more likely to have a disability than men, the World Health Survey indicates that the difference is more likely to be about 60% higher prevalence for women than men.³⁰ The WHO Global Report on Disability cites that across all countries, the prevalence of disabilities, which causes

²⁷ UNDESA, no date

²⁸ WHO, 2011

²⁹ Disabled Peoples International, 2012

³⁰ As cited in WHO, 2011

significant difficulties to an individual, is 12.0% for men and 19.2% for women.³¹ The prevalence of disability is higher amongst those living in poorer countries and the difference in prevalence between men and women appears to be slightly more pronounced in poorer countries (men – 13.8%; women 22.1%).³² Women are also more likely to have severe disabilities compared to men (2.7% versus 1.4%).³³

Africa

Eighty percent of all persons with disabilities live in developing countries. Some 15.5% of Africans (18 million people) are estimated to have moderate to severe disabilities³⁴. The WHO Report on Disability indicates that 3.1% of Africans have a severe disability. This figure is higher than the global average (2.9%) and any other region classified in the low and middle income category. Continental prevalence of people with moderate to severe disabilities is 15.3%; similar to the estimated global prevalence (15.1%) and slightly lower than South-East Asia (16.0%) and Europe (16.4%).

ESA Region

Other than the global estimates, there is limited data available which has been aggregated at the regional level. The East African Community (EAC) has developed a Strategic Plan for Gender, Youth, Children, Persons with Disabilities, Social Protection and Community Development. The guidance prioritises improving the available data on the people with disabilities; however, there is still no evidence of such data. Similarly, the SADC Secretariat and some member states have started discussions about the need for a disability policy for the region attempts at estimating regional prevalence have not yet been made.³⁵

An analysis of country level data, most commonly obtained from country census surveys, indicates a wide range in the prevalence of disability across ESA countries. Country censuses use different indicators (with some indicator types known to result in lower prevalence and some higher) and different cut-off points in the analysis. Therefore reported prevalence rates across countries must be interpreted with caution. Figures range from 1% in Angola³⁶ to 16.8% in Swaziland.³⁷ The average prevalence across 21 countries was 6.73%³⁸. This figure should be regarded with some scepticism, considering that global estimates of disability prevalence are quite a bit higher. It is possible that African countries would, on average, have a higher prevalence of disabilities due to the conditions in which many African people live, including poor access to healthcare (such as immunisations,

³¹ WHO, 2011

³² WHO, 2011

³³ WHO, 2011

³⁴ WHO, 2011

³⁵ Murungi, N. et al., 2012

³⁶ Halvorsen and Ibsen, 2015

³⁷ Swaziland Government, 2010

³⁸ Determined through the authors' calculations; using the prevalence data from the respective countries most recent population census data. Prevalence data for Madagascar and Rwanda could not be found.

screening and treatment), prevalence of armed conflict and the high incidence of motor vehicle accidents. United Nations demographers have said that if the WHO ICF method for measuring disability is used in developing countries, reported disability rates would be higher and closer to the statistics of the OECD countries.³⁹

Some of the challenges and limitations which may compromise the accuracy of reported prevalence data in ESA include:

- Reporting bias – the stigma surrounding disabilities in African countries may result in an under reporting of disabilities
- Quality of data collection – many ESA countries have limited capacity in terms of data collection and data analysis
- Outdated data – limitations related to data collection do result in infrequent data collection efforts and significant delays in the analysis and reporting of data.

In addition, age groups classifications vary by country, for example some countries report data for 16-24 year olds, while others only provide data for 16-49 year olds. Even when looking at the total prevalence (i.e. across all ages) some country data only includes persons aged five years and older. Different countries also have different definitions of disabilities, placing further limitations on the interpretation of comparisons in disability prevalence.

Notwithstanding these limitations, the table below summarises prevalence of disabilities across the ESA region.

Table 1: Prevalence of disabilities (all ages) across East and Southern African countries in order of reported magnitude

Country	Disability prevalence	Country	Disability prevalence
Angola	1.00%	Eritrea	5.00%
Mozambique	2.50%	South Sudan	5.00%
Zimbabwe	2.90%	Tanzania	5.93%
Seychelles	3.00%	South Africa	7.40%
Botswana	3.50%	Ethiopia	9.10%
Lesotho	3.70%	Democratic Republic of the Congo	11.00%
Malawi	3.80%	Uganda	12.40%
Rwanda	3.80%	Comoros	14.90%
Burundi	4.50%	Zambia	15.00%
Kenya	4.60%	Swaziland	16.80%
Mauritius	4.60%	Madagascar	(unknown)
Namibia	4.70%		

³⁹ UNPFA, 2015

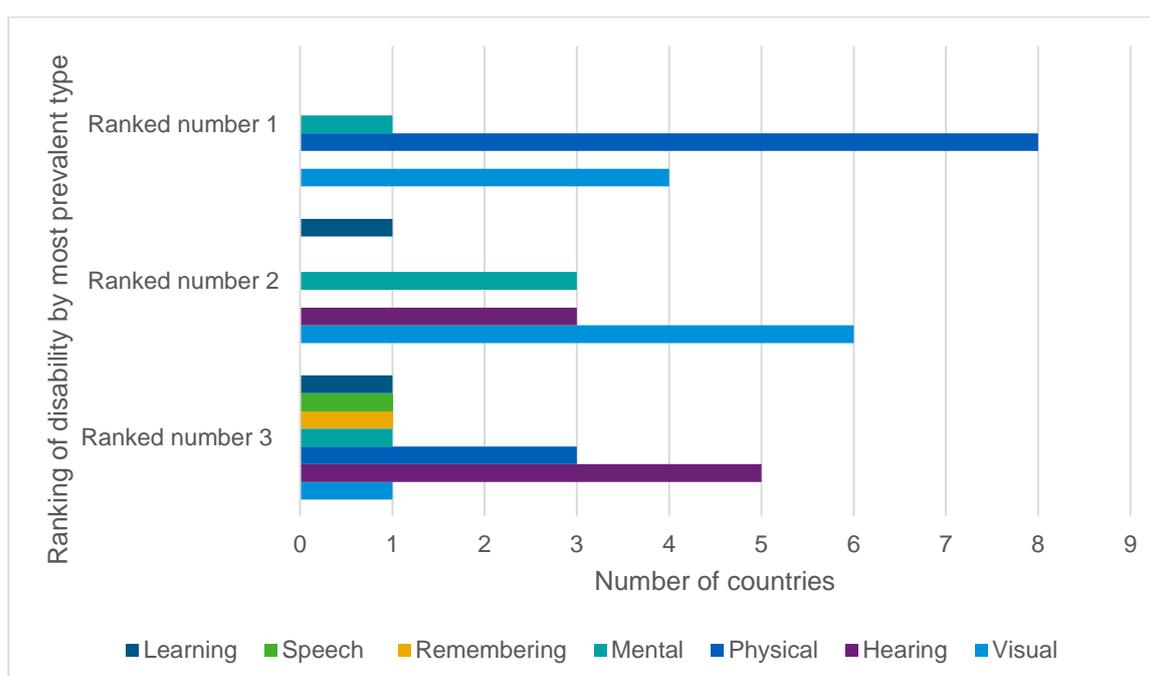
Source: Prevalence data was obtained from the most recent country source available. For detailed reference to sources, refer to individual country profiles reports.

4.1.3 Types of disability

Based on available country level data, the three most common types of disability across the ESA region are physical, visual and hearing disabilities. Other commonly occurring impairments include: mental, remembering, speech functionality and learning disabilities.

For similar reasons to those described above, it is difficult to aggregate this data and determine the regional situation. Definitions of the types of disabilities are not common across ESA countries. It appears that in many countries, when referring to a person with disabilities, it is mostly perceived that one is referring to a person with physical or intellectual disabilities. Therefore, counting of sensory disabilities, for example, may be inaccurate.

Figure 3: Top three disabilities at country level (number of countries that rank the disability in the top three most prevalent disabilities)



Source: Data from 14 ESA countries. Refer to country profiles in the appendix for detailed references

In a review of data from 14 ESA countries, it was found that the causes of disability were much more wide ranging. Illness-related disabilities and congenital disabilities are the most commonly cited causes of disability across the countries in which the data was available. The high prevalence of HIV and AIDS, as well as Malaria, in the region also place the population at risk of disability.⁴⁰ Other causes of disability included those gained through

⁴⁰ WHO, 2011

war or conflict and motor vehicle accidents. In countries where war has been prevalent, injuries from war, mostly related to landmines were the most common cause of impairment.

4.2 Sexual Reproductive Health and Rights

4.2.1 Definitions

SRHR is a complex term incorporating many specific elements but without a single, agreed-upon definition.

The WHO (1975) defines sexual health as the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching.

Petchesky (1995) provides two definitions of reproductive health: firstly, as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes; and secondly, as the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and the information and means to do so, including being free of discrimination, coercion and violence.

UNFPA provides the following definition of SRHR:

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.⁴¹

The International Conference on Population and Development (ICPD) Programme of Action of 1994, in Cairo, Egypt; defined sexual and reproductive rights as follows:⁴²

- Voluntary, informed and affordable family planning services
- Pre-natal care, safe motherhood services, assisted childbirth from a trained attendant and comprehensive infant health care;
- Prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer;
- Prevention and treatment of violence against women and girls, including torture;
- Safe and accessible post-abortion care and, where legal, access to safe abortion services;
- Sexual health information, education and counselling to enhance personal relationships and quality of life.

⁴¹ UNFPA, no date

⁴² Amnesty International USA, no date

If an individual's sexual and reproductive rights are upheld, it assumes that they will have a safe, healthy and enjoyable sex life.

The following definitions are used for the purpose of this Situational Analysis:

Reproductive health is defined by the ICPD Programme of Action as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."⁴³

Sexual health, in turn, is defined as "a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."⁴⁴

Reproductive rights arise out of "established human rights protections; they are also essential to the realization of a wide range of fundamental rights. In particular, the following rights cannot be protected without ensuring that women and adolescents can determine when and whether to bear children, control their bodies and sexuality, access essential sexual and reproductive health information and services, and live lives free from violence"⁴⁵

Sexual and Reproductive Health (SRH) Services are services that include family planning, maternal health, preventing and treating sexually transmitted infections including HIV and AIDS, abortion and health information sharing.

Sexual and Reproductive Health and Rights (SRHR) Services include SRH Service as well services focusing on rights based approaches, violence prevention and management, access to justice and comprehensive sexuality education.

⁴³ ICPD, 1994; UNFPA, no date

⁴⁴ Ibid

⁴⁵ Ibid

The UNCRPD mandates State parties to uphold the rights of persons with disabilities with respect to sexual and reproductive rights. Some of the key obligations related to ensuring SRHR include:⁴⁶

- protect persons with disabilities from violence, exploitation and abuse (including the gender-based aspects of such violations) (CRPD Art. 16);
- ensure that persons with disability are not subjected to arbitrary or unlawful interference with their privacy (CRPD Art. 22) and family (CRPD Art. 23), including in all matters relating to marriage, family, parenthood and relationships; guarantee persons with disabilities, including children (CRPD Art. 7),
- ensure that persons with disability enjoy the right to retain their fertility; take measures to ensure women and girls enjoy the full and equal enjoyment of their human rights (CRPD Art. 6);
- prevent people with disabilities from being subjected to torture, or cruel, inhuman or degrading treatment or punishment (CRPD Art. 15);
- prohibit involuntary treatment and involuntary confinement (CRPD Arts. 12, 17 and 25);
- ensure the right of people with disabilities to the highest attainable standard of health without discrimination, including in the area of sexual and reproductive health and population-based public health programs (CRPD Art. 25).

Sexual and reproductive services

Sexual and reproductive health services include family planning, maternal health care, preventing and managing gender-based violence, and preventing and treating sexually transmitted infections including HIV/AIDS.⁴⁷ Some of the specific services within these are detailed in the table below:

Table 2: SRHR services

Service group	Types of services
Overarching	<ul style="list-style-type: none"> • Comprehensive Sexuality Education
Family planning	<ul style="list-style-type: none"> • Contraceptive pills, injections, implants etc. • Intra-uterine devices (IUD) • Natural family planning • Male and female condoms • Diaphragm • Safe abortion
Maternal healthcare	<ul style="list-style-type: none"> • Pre-natal and antenatal care • Child birth • Neonatal care

⁴⁶ Frohmader & Ortoleva, 2013

⁴⁷ WHO, 2011

Service group	Types of services
	<ul style="list-style-type: none"> • eMTCT (elimination of Mother to Child Transmission)
Preventing and managing gender-based violence	<ul style="list-style-type: none"> • Rape kits • Forensic examination • Counselling and support • Other relevant medical treatment
Preventing and treating sexually transmitted diseases	<ul style="list-style-type: none"> • HIV counselling and testing (HCT) • HPV vaccines • Pap smears • Circumcision • Provision of drugs for treatment e.g. Antiretroviral drugs (ARVs)
Other reproductive health	<ul style="list-style-type: none"> • Mammograms • Screenings for male cancers (testicular, prostate etc.)

4.2.2 The family planning agenda

Family Planning (FP) 2020 is a global initiative that works to scale up access to and use of contraceptives by woman and girls to 120 million by 2020. FP 2020 is also a key milestone in ensuring universal access to SRH services and rights by 2030. The initiative came about as an outcome of the 2012 London Summit on Family Planning where governments made commitments to address the policy, financing, delivery and socio-cultural barriers when it comes to woman and girls and their access to contraceptives. Since its initiation, FP 2020 has grown from including 20 governments in 2012 to 36 governments to date. In 2014, FP 2020 secured US\$ 2.6 billion in donor funding.

Thus far, FP 2020 has involved governments, civil society, multilateral organizations, donors, the private sector, and the research and development community in furthering its initiative. Within ESA, Mozambique, Zambia, Zimbabwe, Lesotho, Malawi, Tanzania, Madagascar, Burundi, Rwanda, DRC, Uganda, Kenya, Eritrea, South Sudan, Comoros and Ethiopia are all focus countries of the FP 2020 movement.⁴⁸

4.2.3 Demand for SRHR services

Large numbers of people in ESA have poor access to SRHR services, and it appears that access to these services is even more challenging for young persons with disabilities. Some

⁴⁸ Family Planning 2020, 2017. About Us. [Online]. Available: <http://www.familyplanning2020.org/about> [Accessed 26 September, 2017]

of the significant challenges include access to contraception; appropriate antenatal services; and lack of care for complications during pregnancy and delivery (and thereafter).⁴⁹

Access to contraception

It is estimated that some 55 million women (40% of women aged 15-49 years) in sub-Saharan Africa want to prevent pregnancy but are not using an effective contraceptive.⁵⁰ An analysis of the data collected from 1128 sexually active, women with disabilities in Uganda found that 77% of women between 15-25 years have never used any form of contraception.⁵¹ Further to this, 73% of women (aged 15-49 years) who reported not wanting to have any more children, had never used any form of contraception. A study conducted in Ghana, showed that contraceptive use amongst deaf people was low. Only 32% of deaf women, compared to 46% of deaf men have ever used contraception. Of the sample, 36% of those aged between 18 and 22 years, have ever used contraception, compared to 47% of those older than 22 years.⁵²

Access to safe abortion

Unsafe abortion can cause disability and can be fatal. The incidence of abortion is not related to abortion legality, meaning that the number of terminations is similar irrespective of whether abortion is legal or illegal. Even where abortion is legal, due to the associated stigma and lack of access to appropriate services, the rate of unsafe abortion is high. While data on unsafe abortion is hard to find, it was estimated in South Africa, where abortion is legal under specific timeframes and conditions, that almost 50% of all abortions undergone by women and girls aged 13 to 19 took place outside a hospital or clinic and were therefore likely to be unsafe.⁵³

Maternal Healthcare

Only half of pregnant women in the region access the suggested minimum four antenatal visits; and a similar figure give birth in a healthcare facility.⁵⁴ Amongst the poorest households, only 26% of women will give birth in a healthcare facility.⁵⁵ Data for women with disabilities was not available.

⁴⁹ Guttmacher Institutes and UNFPA, 2014

⁵⁰ Guttmacher Institutes and UNFPA, 2014

⁵¹ Ayiga and Kigozi, 2016

⁵² Mprah. W.K, 2013

⁵³ Medical Research Council report, cited on ngopulse.org (accessed 29 September 2017)

⁵⁴ Guttmacher Institutes and UNFPA. 2014.

⁵⁵ Guttmacher Institutes and UNFPA. 2014

Prevention and treatment of sexually transmitted infections

Sexually transmitted infections (STI), including those caused by HIV, are a major public health problem in Africa, and cause a significant number of deaths through, amongst others, AIDS, cervical cancer, congenital syphilis, ectopic pregnancy, HIV-related illness.⁵⁶

One example of the scale of the impact of STIs in Sub-Saharan Africa is the human papillomavirus (HPV). HPV is a sexually transmitted infection which can cause cervical cancer. Cervical cancer is the most common form of female cancer in sub-Saharan Africa.⁵⁷

HPV prevalence was 34% among a random sample of women from rural Zimbabwe⁵⁸, 34% among 660 pregnant women in Mwanza, Tanzania⁵⁹, and 44.3% among family planning clinic attendees in Nairobi, Kenya⁶⁰. Data from population-based cancer registries describe age-standardised incidence rates of cervical cancer of 41.7 per 100 000 in Kyadondo, Uganda, and 55.0 per 100 000 in Harare, Zimbabwe.⁶¹

Despite there being two HPV vaccines available, five times more women are diagnosed with cervical cancer in Africa than in North America; and almost eight times more women die from cervical cancer in Africa than in North America every year. Further to this, the large majority of cervical cancer cases in Africa are diagnosed very late. The advanced stages of the disease have a very poor prognosis.⁶² The prevalence and experience of the disease for women with disabilities is not known due to a lack of data.

4.2.4 Sexual and reproductive rights violations

Given the broad and encompassing definition of SRHR, violations of SRHR are similarly wide-ranging. The following are examples of SRHR violations:⁶³

- Forced and/or coerced sterilisation
- Forced contraception
- Gender based violence (including physical, sexual, emotional, psychosocial and financial violence)
- Female genital cutting and forced male circumcision

⁵⁶ Lewis, 2011

⁵⁷ WHO, 2015

⁵⁸ Baay *et al.*, 2004, cited in Clifford and Franceschi, 2005

⁵⁹ Mayaud *et al.*, 2001, cited in Clifford and Franceschi, 2005

⁶⁰ De Vuyst *et al.*, 2003, cited in Clifford and Franceschi, 2005

⁶¹ Parkin *et al.*, 2002, cited in Clifford and Franceschi, 2005

⁶² WHO, 2015

⁶³ Frohmader, C. and Ortoleva, S, 2013

- Denial of maternity, parenting and parental rights
- Denial of legal capacity and decision making
- Lack of access to SRHR and programmes
- Lack of access to information and education on SRHR
- Lack of access to justice

Forced and/or Coerced Sterilisation

Forced and/or coerced sterilisation of women and girls with disabilities is common practice globally.⁶⁴ These procedures are often performed forcibly under the pretext of having the women's best health interest in mind.⁶⁵ Although the practice has significant human rights implications, the offenders rarely are held responsible for their actions.⁶⁶

Forced Contraception

Women and girls with disabilities can be forced to use contraception to control menstruation, sexual expression and/or fertility.⁶⁷ The common misconceptions around the reproductive capacity of women and girls with disabilities often means that they are denied access to safe and effective contraceptives of their choice. Women and girls with disabilities often lack information and are less likely to be given a choice of contraceptives. Some women and girls with disabilities are sterilised or prescribed long-lasting contraceptives against their will.⁶⁸

Gender-based violence

The intersection of socio-cultural practices that perpetuate gender-based violence (GBV) and disability related discrimination leads to women and girls with disabilities being at heightened risk of GBV in ESA countries.⁶⁹ Violence against women and girls with disabilities often perpetuates in various sectors of society, such as the home and communities, and includes physical, psychological, and sexual violence amongst others. GBV can also lead to disabilities among women and girls.

Female genital cutting and forced male circumcision

Cultural practices such as female genital cutting is also considered as gender-based violence. The rate of female genital cutting is as high as 21% and 10% in Kenya and the

⁶⁴ Méndez, Juan. E, 2013

⁶⁵ WWDA, Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA), 2011

⁶⁶ Frohmader, C. & Ortoleva, 2013 S. and Lewis, H. 2013

⁶⁷ Frohmader, C. & Ortoleva, 2013

⁶⁸ O'Connor, no date

⁶⁹ Manjoo, 2012

United Republic of Tanzania respectively.⁷⁰ Forced circumcision of men and boys is also a common cultural and traditional practice across ESA, often as part of an 'initiation' practice. A landmark South African court case in 2009 ruled that in South Africa, circumcision is unlawful unless done with the full consent of the initiate.

Denial of maternity, parenting and parental rights

Women with disabilities are often deterred of or denied of their maternity, parenting and parental rights. In some cases, parental rights have been terminated, and children removed from their care, based on their disability as opposed to their parental capabilities. Furthermore, women with disabilities that have children can be forced into having hysterectomies to prevent them from having more children.⁷¹

Denial of legal capacity and decision-making

Women with disabilities may be denied legal capacity as a result of stigma and discrimination, or judicial declaration of incompetency based on their disability. Women and girls with disabilities are often denied SRHR by using their incapacity as a justification.⁷²

Lack of access to SRHR and programmes

Women with disabilities experience several challenges regarding their access to SRHR services and programmes. These include social, economic, physical, psychological, structural and cultural barriers. The attitudes and perceptions of health care practitioners can contribute to challenges experienced by women with disabilities.⁷³ In many instances, healthcare practitioners lack the necessary education and training to provide adequate SRHR services to women with disabilities.⁷⁴

Lack of access to information and education on SRHR

SRHR knowledge and information among women with disabilities is generally limited. More so there is a significant lack of appropriate and accessible information and education regarding SRHR for women and girls. While there have been significant efforts by ESA governments to roll out comprehensive sexuality education programmes across schools, young persons with disabilities are less likely to attend school than young persons without disabilities and there is an increased risk they will not receive this educational support. The lack of information refers to the absence of relevant content and materials that support the needs of women and girls with disabilities and also the availability of information in an appropriate format such as Braille, audio, in sign language, etc.

⁷⁰ Eannaso, 2017

⁷¹ O'Connor, no date

⁷² O'Connor, no date

⁷³ Mall & Swartz, 2012

⁷⁴ UNESCO, 2016

Lack of access to justice

Women and girls with disabilities, in particular those with intellectual or cognitive disabilities, often lack access to justice. These women and girls are often excluded from participating in legal processes on the basis of their type of disability. Firstly judicial services are not designed universal and lack reasonable accommodation including sign language or Braille. Secondly they may not be considered as a reliable witness and therefore cannot report violations against their rights. This leaves women and girls with intellectual or cognitive disabilities especially vulnerable to violence and abuse.⁷⁵

4.3 “Intersectionality” of age, gender, disability and other factors in the context of SRHR

In light of the previous sections, there is significant evidence that the experiences of young people with disabilities on their own have many challenges. In addition, accessing SRHR services introduce challenges for many persons regardless of who they are or where they come from. This section acknowledges specifically the experience of young persons with disabilities in accessing SRHR, i.e. the “intersectionality” of age, disability, gender with respect to access to SRHR, and the unique and often exacerbated challenges thereof.

The analysis that follows is not intended to be a comprehensive analysis of the various intersectionalities, but provide the reader with an indication of the number and complexity of the factors that make up the specific and unique experience of an individual young person with disabilities.

WE DECIDE⁷⁶ describes the impact that living with a disability has on SRHR. In light of the increased risk for violence, sexual abuse and exploitation, young persons with disabilities are particularly vulnerable, yet young persons with disabilities are often excluded from SRHR programmes and experience barriers (physical, communication etc.) when trying to access SRHR services. Young persons with disabilities become sexually active and experience their sexuality as early and as often as young people without disabilities. A review of the most recent Demographic Health Surveys across twelve ESA countries, for this situational analysis, reveals that approximately 12% of all young females and 14% of all young males (15-24 years) have experienced sexual debut before the age of 15.⁷⁷ The concern is that sexual debut occurs without adequate information on contraception, consent and other

⁷⁵ Frohmader et al., 2013

⁷⁶ UNFPA, 2015

⁷⁷ This was calculated using RAW DHS and MICS data from 12 ESA countries: DRC (2013-14 DHS), Ethiopia (2011 DHS), Kenya (2014 DHS), Lesotho (2014 DHS), Malawi (2010 DHS), Mozambique (2011 DHS), Namibia (2013 DHS), Tanzania (2010 DHS), Uganda (2010 DHS), Zambia (2013-14 DHS) and Zimbabwe (2013/14 MICS)

rights, and makes such young people especially vulnerable to abuse and violations of their rights.

In most ESA countries, young people's sexuality and sexual activity is a taboo subject, and viewed as something that should be prevented, discouraged, suppressed or forbidden. As a result, young persons with disabilities face significant barriers to access information, education and services in sexual and reproductive health that are adequate, comprehensive and free of prejudice. At the same time, unwanted pregnancies, sexually transmitted infections (STIs) including HIV/AIDS, harassment and sexual violence, to which many young persons with disabilities are exposed, are a major threat to their personal development, health and quality of life.

Internationally it has been recognized that in order to ensure that sexuality is a healthy part of life, young persons, including those with disabilities, need the information, education and services so that they can make informed decisions about their sexuality and reproduction. Hence young people with disabilities need access to comprehensive sexuality education and prevention programmes. This will also strengthen efforts to reduce gender-based violence and/or sexual abuse/violence and increase demand to access justice. The reality in the ESA region, however, is that inclusion of young persons with disabilities in mainstream education or out of school youth programmes with comprehensive sexuality education and prevention programmes is mostly absent. This section touches on some of the specific challenges faced by young people with disabilities with regards to accessing SRHR and services; and how other characteristics further add to the vulnerability of young persons with disabilities.

Sexual activity

Young persons with disabilities in ESA are engaging in sexual activities. This includes both consensual and non-consensual sexual activities. There is evidence that young persons with disabilities are engaging in high risk sex; including having multiple partners,⁷⁸ not using any form of contraception, including condoms⁷⁹ and engaging in transactional sexual relationships.⁸⁰ Research in Ethiopia found that that 52% of young persons with disabilities were sexually active, 75% of them had sex for the first time between the ages 15-19. Data collected amongst young persons with disabilities in Nigeria found that the average age of sexual debut was 15 years.⁸¹ In Ethiopia, 59% of sexually-active young persons with disabilities were found to have multiple lifetime sexual partners, 19% had a casual sexual partner, and 21% a commercial sexual partner.⁸²

⁷⁸ Oladunni, 2012, Alemu & Fantahun, 2011

⁷⁹ Alemu and Alemu & Fantahun, 2011

⁸⁰ Oladunni, 2012, Alemu & Fantahun, 2011

⁸¹ Oladunni, 2012

⁸² Kassa et al, 2014

Knowledge of SRHR

Several studies have shown that young people with disabilities have less knowledge about SRH or HIV when compared to their peers without disabilities. In Ethiopia, young persons with disabilities were found to be aware of SRHR and services, sexually transmitted diseases, and reproduction, but many lacked depth of knowledge.⁸³ Three quarters of the young people studied had heard of STIs but 53% could not name different types of STIs.⁸⁴ A key limitation of this study was that it did not compare these results to persons without disabilities. A similar later study found that knowledge surrounding HIV appeared to be generally low amongst young persons with disabilities. While a large majority of young persons with disabilities knew what HIV is, there were low levels of knowledge regarding how to prevent HIV.⁸⁵ In addition, perceptions of risk of infection were low. Only 21% of young persons with disabilities believed that they were at risk of contracting HIV.⁸⁶ This is despite the evidence that young persons with disabilities are engaging in sex as much and as frequently as their young people without disabilities.

Many young persons with disabilities lack awareness about their SRHR and the services available to them. Those who are isolated in their homes, with little access to information tend to be the most vulnerable. A study conducted in Uganda among home-based young persons with disabilities revealed that some were not familiar with the notion of sexual intercourse and only one was aware of the concept of family planning.⁸⁷

Understanding and use of contraception

The most frequently used form of contraception is the male condom. One study found that only two in five young persons with disabilities knew about modern forms of contraception.⁸⁸ The Ethiopian research found that only 35% of young persons with disabilities used contraceptives during their first sexual encounters.⁸⁹ In the same study, 62.5% of young persons with disabilities had had an unintended pregnancy and of these 50% of them had terminated the pregnancy via an abortion.⁹⁰

Sexuality education

School education is commonly seen as a key entry point to provide sexuality education (including comprehensive sexuality education) to young people regardless of their socio-

⁸³ Kassa et al, 2012

⁸⁴ Kassa et al, 2012

⁸⁵ Kassa et al, 2016

⁸⁶ Kassa et al, 2016

⁸⁷ Tanabe et al, 2015

⁸⁸ Olajide et al, 2014

⁸⁹ Kassa et al, 2014

⁹⁰ Kassa et al, 2014

cultural background. Hence schools are also seen as a key institution for young persons with disabilities to acquire knowledge about sexuality and SRHR.

In Africa, the silence surrounding sexuality transmits into the classroom, with learners not accessing crucial information that goes beyond the abstinence only approach (reference Kirby, UNFPA). These socio-cultural challenges are exacerbated in the context of disability, where educating learners with disabilities might be seen as too difficult, not appropriate or not necessary.

Several studies in Africa have provided information on the challenges of sexuality education in school for learners with disabilities. A study conducted with 99 teachers in 10 special schools in South Africa revealed that teachers were more inclined to address the “softer topics” on sexuality such as love and friendship, and were less comfortable with topics such as marriage, masturbation, abortion and sexual abuse.⁹¹ Although educators recognise sexuality education as part of the South African Life Orientation curriculum they identified a number of challenges including barriers in communication and language, cultural values and expectations, learners’ knowledge and behaviour, educators skills with regards to teaching but also handling of sexual abuse cases. A large majority (90%) of teachers expressed the need for more materials to teach on sexuality and 47.5% found existing materials to be unsuitable for their learners.⁹² Thus even if teachers are willing to teach more comprehensively about sexuality they are often limited by materials which do not adequately cater for young persons with disabilities. These findings have been echoed in other studies from Africa highlighting educators’ troubling experience between a human-rights discourse and lack of socio-cultural support and teaching skills.

Across the studies that were reviewed, very few young persons with disabilities reported accessing information regarding SRHR from a healthcare professional or educator. For instance in Ethiopia, the majority (62%) indicated that they obtained their information from the television and radio.⁹³ Almost 80% of the same youth indicated that they had never discussed anything to do with sex or their own sexual health with their parents.⁹⁴ Adolescents in Southwest Nigeria reported that their primary source of sexual and reproductive health information was their friends.⁹⁵ Only one in three young persons with disabilities reported having ever accessed any sexual and reproductive health services.⁹⁶

⁹¹ Chirawu et al, 2014

⁹² Chirawu et al, 2014

⁹³ Kassa et al, 2014

⁹⁴ Kassa et al, 2014

⁹⁵ Oladunni, 2012

⁹⁶ Alemu & Fantahun, 2011

Sexual abuse

The threat of gender based violence (GBV) makes women and girls with disabilities particularly vulnerable and in need of SRHR and services. Current research on GBV shows that women and girls with disabilities are more vulnerable than their able bodied peers. However, not much is written on their vulnerability in relation to boys and men with disabilities. Women with disabilities have a 40% higher chance of experiencing an intimate partner violate them than women without disabilities. Almost half of the young persons with disabilities in the Ethiopian study reported that they had been victims of sexual violence during their lifetime.⁹⁷ Girls with an intellectual disability in Nigeria were found to be five times more likely to report a history of sexual abuse than girls without disabilities.⁹⁸ These studies shine light on the need for young persons with disabilities, particular women and girls, to be empowered and protected in relation to their SRHR.

HIV status

A growing number of reports has also indicated that persons with disabilities are at increased risk for every known risk factor for HIV/AIDS.⁹⁹

The experiences of HIV positive women with disabilities and men with disabilities are quite different, with the former being more vulnerable to abandonment. A study of HIV prevalence amongst young persons with disabilities in Rwanda, found that HIV was more prevalent amongst young persons with disabilities (5.73%) than the general population (3.0%).¹⁰⁰ Similar to the general population, young women with disabilities are disproportionately affected by HIV compared to their male counterparts.¹⁰¹ One study conducted among HIV positive men and women concluded that “being male appeared to create space for support regardless of the disadvantages of being HIV-positive and having a disability.”¹⁰² Many of the women in the study had been left by their husbands or boyfriends once becoming HIV positive or acquiring a disability, some even left to take care of their children alone.¹⁰³ Therefore, in addition to the statistics on GBV, HIV further entrenches the vulnerability of women with disabilities suggesting a need for a disproportionate policy focus on them.

Sexual orientation and gender identity

Persons who identify as gay, lesbian, bi-sexual, transgender and intersex (LGBTI) are particularly vulnerable to stigma and cultural attitudes which can restrict access to services. While men who have sex with men are a key population in programmes to prevent and

⁹⁷ Kassa et al, 2014

⁹⁸ Chirawu et al, 2014

⁹⁹ Hanass-Hancock, 2009

¹⁰⁰ Munymana et al, 2014

¹⁰¹ De Beudrap et al, 2014

¹⁰² Yoshida et al, 2014

¹⁰³ Yoshida et al, 2014

eliminate HIV, in reality the attitudes of local service providers are often a barrier to access. Persons who identify as LGBTI are highly vulnerable to be “left behind” in mainstream efforts to improve access to SRHR.

Marital status and family environment

Young persons with disabilities are also made vulnerable by the family environments which they come from.

Unmarried women with disabilities are particularly vulnerable to being unable to access their SRHR and services. In most African cultures, a woman who loses her virginity before marriage, whether she is a woman with disabilities or not, is frowned upon. Therefore the sexual and reproductive agency of a young female with a disability is often linked to her marital status.

A study conducted with a group of Somali refugees with disabilities based in Uganda found that if a woman with a disability fell pregnant outside of wedlock, practice could dictate that she be forced to abort the child because of the religious shame and reputational damage that would bring the family.¹⁰⁴

In addition, women with disabilities are less likely to be married, women with children with disabilities are more likely to be left by the father or husband.

Rights to reproduce

Even in cases where the conditional acceptance based on marriage holds, young women with disabilities might still hesitate to exert their reproductive rights because of other cultural deterrents. Young persons with disabilities begin to internalise the dominant cultural narratives about their SRHR, often sharing sentiments which do not uphold their own SRHR.

A study of young persons with disabilities in a refugee camp in Uganda showed that 25% of young persons with disabilities thought that forced sterilization was acceptable stating that “if a person has heavy disability and is disturbing the family, they [the family] may have the person sterilized.”¹⁰⁵ Forced sterilization, abortions and family planning violate the fundamental human rights of young persons with disabilities and diminish their autonomy with regards to their SRHR. Young persons with severe or intellectual disabilities are the most likely to experience violation of their rights.

Personal capacity

The literature indicates that young persons with disabilities are not necessarily equipped with the correct knowledge to engage in safe sexual activity and that their environments may not be conducive to building their capacity to practice safe sexual activity. Young

¹⁰⁴ Tanabe et al, 2015

¹⁰⁵ Tanabe et al, 2015

persons with disabilities in Uganda and Rwanda reported low self-esteem and issues of self-efficacy, affecting their ability to engage in safe sexual relationships.¹⁰⁶

Types of disability and access

A study in Uganda and Rwanda identified that access to SRHR information (and in particular HIV-related information) was influenced by the type of and degree of disability.¹⁰⁷ In particular, individuals who had hearing or visual impairments were unable to access information because of the communication challenges they faced. Expressing the information in sign language is a challenge for parents, educators and healthcare providers; and appropriate print material remained inaccessible for visually impaired individuals. Individuals with physical impairments experience challenges in accessing to buildings and facilities where they could obtain information.¹⁰⁸ Overall, challenges to access occur when access is not based on universal design, as described in the UNCRPD.

Continuum of vulnerability

Depending on a range and combination factors, these interweaving identities place young persons with disabilities in extremely vulnerable positions in relation to their SRHR. Each individual's lived experience means they have a different combination of factors which contribute towards their vulnerability. Therefore, every individual lives on a type of continuum of vulnerability where your personal, family, community and broader societal environment influences your position on the continuum.

Indeed, not all experiences of this intersectionality are vulnerable. Some young persons with disabilities may be able to use their circumstances to negotiate for access. One study found examples where young persons with disabilities used their HIV status to create positive health care experiences, with one man in particular noting that he was able to receive preferred treatment and never had to wait in queues as a result of his HIV and disability status¹⁰⁹. Unfortunately, such examples are in the minority.

4.4 Socio-ecological view of access to SRHR

The experience of young persons with disabilities, and their experience of vulnerability, is influenced by numerous factors, including individual characteristics, relationships within family and society, the nature of those relationships and the physical and societal environment in which they live.¹¹⁰ The socio-ecological model provides a good basis to understand the various levels which influence the ability of young persons with disabilities to

¹⁰⁶ Yousafzai et al., 2009

¹⁰⁷ Yousafzai et al., 2009

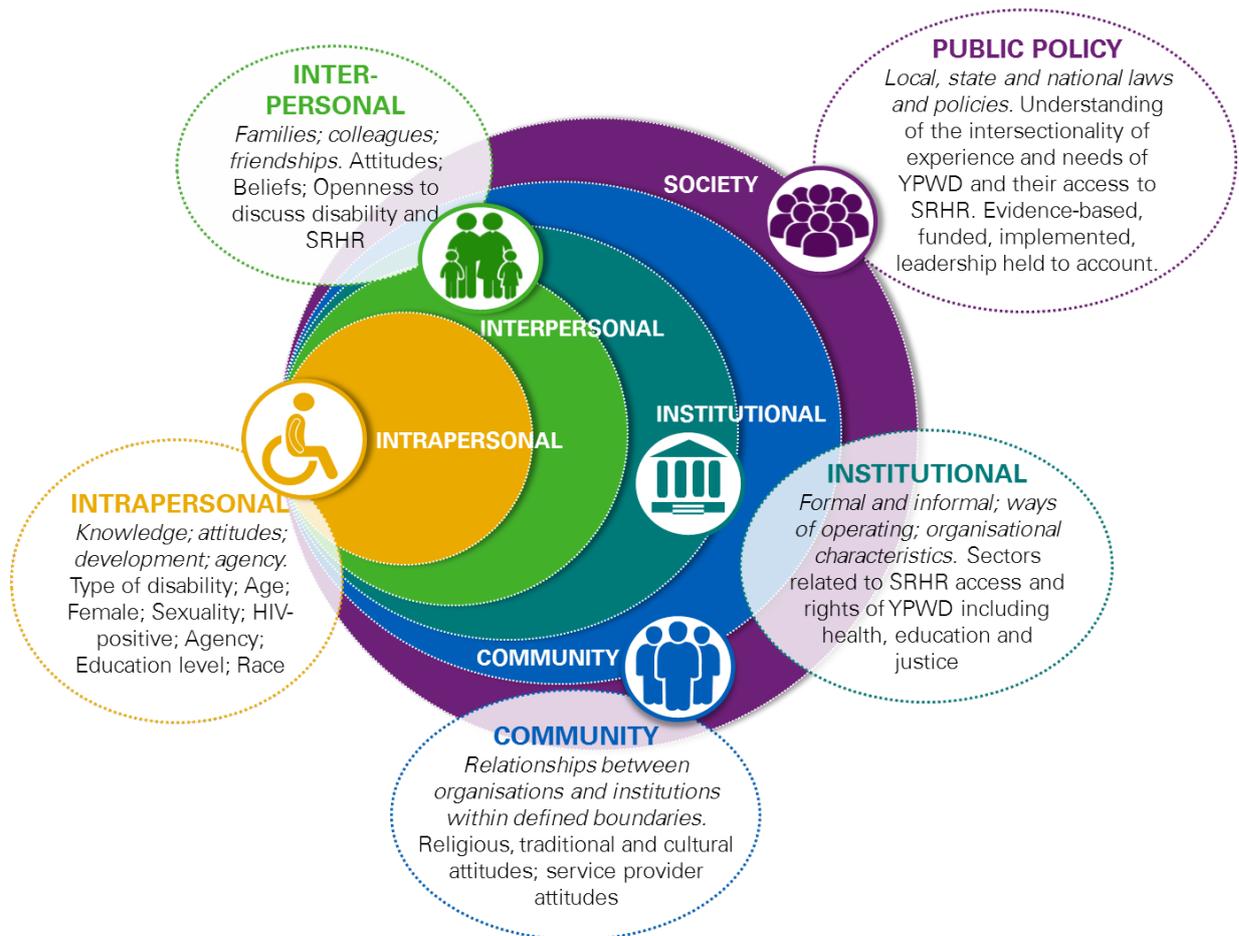
¹⁰⁸ Yousafzai et al., 2009

¹⁰⁹ Yoshida et al, 2014:4

¹¹⁰ Singh et al., 2014

access SRHR services. The figure below illustrates the multiple levels which contribute to a multi-faceted view of access to SRHR services. These levels are: intrapersonal; interpersonal; institutional; community; and public policy. In the figure below, the italicised words elaborate on what is meant by each level, and the non-italicised words provide considerations of the specific factors related to access to SRHR services by young persons with disabilities in that socio-ecological level.

Figure 4: Socio-ecological approach to access to SRHR by young persons with disabilities



Source: adapted from McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988)

The socio-ecological model proposes that interventions are more likely to be effective when they address the determinants of an issue across these five levels. Therefore the regional guidance to improve access to SRHR services by young persons with disabilities needs to consider the intersectionality of a young person’s specific experience (their ‘intrapersonal’ experience) and their experience at different levels, including interpersonal, institutional, community and policy levels. The socio-ecological model provides part of the framework for this situational analysis and its application is discussed further in Part 2.

4.5 ESA SRHR and young persons with disabilities development partners

The ESA region receives strong support from development partners from the donor community. The Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and the United States' Presidents Emergency Plan for AIDS Relief (PEPFAR) have played important roles as contributors to the HIV responses of the countries in this region. These development partners have supported the provision of commodities and products, programmatic support and capacity building in governments, research and sharing of lessons learned and best practices across the region.

The prioritisation and provision of SRHR services in the region has been supported by UN agencies, particularly UNFPA as part of its core mandate but also by other agencies such as UNESCO and UNICEF, which have supported CSE specifically. Other major donors in the region include bilateral and regional programmes of the European Union, Sweden and the United Kingdom. Some countries, such as Lesotho, depends heavily on external funding for the provision of SRHR services to citizens.

Some of the key development partners which support objectives to improve access to SRHR services for young persons with disabilities in ESA are summarised in the table below:

Table 3: Key development partners for SRHR and young persons with disabilities

The table below provides a summary of key development partners for SRHR and/or young persons with disabilities in ESA. Some partners are funders, some are implementing partners and some play a combination of roles in the region.

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
DFID	The Department for International Development (DFID – also referred to as UK AID) leads the British government’s development programmes to end extreme poverty, building a safer, healthier, and more prosperous world. DFID’s high level objectives are to end the need for aid by creating jobs, unlock the potential of girls and women and help to save lives when humanitarian emergencies hit.	Ethiopia Kenya Malawi Mozambique Rwanda South Africa South Sudan Tanzania Uganda Zambia Zimbabwe	With respect to SRHR, DFID states a firm commitment to realising international SRHR targets, particularly given their relevance to achievement of the SDGs. DFID also has a specific HIV/AIDS strategy which highlights synergies with SRHR, and gender inequality (DFID 2005).
Dutch Ministry of Foreign Affairs	The Dutch government’s aim is to contribute to reducing maternal mortality rates, curbing the spread of HIV/AIDS and preventing unwanted pregnancies, especially among teenagers. This will not only benefit the people themselves, but also boost social and economic progress in the countries in question. Priority themes for funding including water and sanitation, food security, SRH (including HIV/AIDS), and security and legal order.	Burundi Ethiopia, Kenya, Mozambique Rwanda South Sudan Uganda	Among the initiatives supported by the Dutch Ministry of Foreign Affairs are: <ul style="list-style-type: none"> - Promoting and marketing affordable female condoms - Strengthening the profession of midwives, for example through training - Social franchising to expand SRH services through private practitioners - Training young people through the Youth-Peer programme and other youth networks and

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
			<p>organisations in which young people teach each other about HIV/AIDS and SRHR</p> <p>The Ministry partners with a number of organisations, including:</p> <ul style="list-style-type: none"> - Aids Fonds - Cordaid - Plan Nederland - Rutgers - Save the Children - Stichting Kinderpostzegels - Terre des Hommes.
Europe Aid	The European Union is a unique economic and political union between 28 European countries that together cover much of the continent. One of the EU's main goals is to promote human rights both internally and around the world. Human dignity, freedom, democracy, equality, the rule of law and respect for human rights: these are the core values of the EU.	Sub- Saharan Africa	<p>The European Commission, through Europe Aid, has provided €32 million in assistance to 22 African, Caribbean and Pacific (ACP) countries over a period of 6 years to help fight poverty and to increase access to and quality of SRH services and commodities to the most vulnerable and underserved people¹¹¹.</p> <ul style="list-style-type: none"> - Develop reliable and efficient health systems able to respond to the health needs of the population - Guarantee the rights of women, men and adolescents to good sexual reproductive health - Reduce maternal mortality

¹¹¹ EuropeAid, 2017

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
			<ul style="list-style-type: none"> - Guarantee universal access to a complete range of secure, effective, accessible and acceptable health services
Global Fund to fight AIDS, Tuberculosis and Malaria	<p>The Global Fund is a partnership organisation designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics.</p> <p>The Global Fund is one of the largest supporters of HIV/AIDS programmes worldwide and is committed to country ownership of programmes that evolve from national plans and priorities. Thus, Global Fund is in support of sexual and reproductive health as essential in helping countries control their epidemic of HIV infection.</p>	Angola Botswana Burundi DRC Comoros Eritrea Ethiopia Kenya Lesotho Madagascar Malawi Mauritius Mozambique Namibia Rwanda South Africa South Sudan Swaziland Uganda Tanzania Zambia Zimbabwe	<ul style="list-style-type: none"> - The Global Fund focuses its work on: - Human Rights - Sexual and Reproductive Health and Rights - Community Responses and Systems - Key Populations - Women and Girls - Resilient Systems for Health - Domestic Financing - Equitable Access Initiative
Handicap International	Handicap International (HI) works in situations of poverty and exclusion, conflict and disaster. The organisation aims to respond to the essential needs, improve the living conditions and promote respect for the dignity and fundamental rights of people living with disabilities.	Angola Burundi DRC Ethiopia Kenya Madagascar Mozambique Rwanda South Sudan	The work of HI focuses on: <ul style="list-style-type: none"> - supporting DPOs - support to rehabilitation centres - socioeconomic inclusion - inclusive education - child health - reducing sexual violence against children

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
	While HI does not specifically address the SRHR needs of young persons with disabilities, they do advocate for the universal recognition of the rights of people with disabilities through national planning and advocacy. One component of their work is 'protecting the right to healthcare'. This includes various types of support including financial support.	Tanzania Uganda	<ul style="list-style-type: none"> - rehabilitation - maternal and child health, - logistic services - road safety - assistance to refugees and host communities - climate change and disability
International Planned Parenthood Federation (IPPF)	The International Planned Parenthood Federation Africa Region (IPPFAR) is the leading non-government SRHR service delivery organization in Africa and the leading SRHR advocacy voice in the region. The organisation's overarching goal is to increase access to SRHR services and support for sub-Saharan's Africa most vulnerable youth, men and women ¹¹² .	Angola Botswana Burundi DRC Comoros Ethiopia Kenya Lesotho Madagascar Malawi Mauritius Mozambique Namibia Rwanda South Sudan Swaziland Uganda Tanzania Zambia	<p>In 2015, IPPF provided 175.3 million sexual and reproductive health services. It also contributed to 82 policy and/or legislative changes in support or defence of sexual and reproductive health and rights in 48 countries¹¹³.</p> <p>IPPFAR focuses its work on:</p> <ul style="list-style-type: none"> - Support actions to increase to increase access by strengthening IPPFAR's SRHR leadership position in the region - Ensure increased access to integrated, quality sexual and reproductive health and rights services and information by using gender, rights-based and quality of care approaches - Build regional capacity to increase access by strengthening institutional and operational efficiency

¹¹² International Planned Parenthood Federation, 2017

¹¹³ International Planned Parenthood Federation, 2017

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
			<ul style="list-style-type: none"> - Enhance organizational learning and accountability to stakeholders
Save the Children	<p>Save the Children is a global leader in improving children’s health. The organisation uses evidence-based approaches to tackle life-threatening conditions, reaching as many children as possible.</p> <p>Their mission is to achieve a world in which every child attains the right to survival, protection, development and participation. ¹¹⁴.</p>	Botswana DRC Ethiopia Kenya Lesotho Madagascar Malawi Mozambique Namibia Rwanda South Africa South Sudan Swaziland Tanzania Uganda Zambia Zimbabwe	<p>Save the Children’s work focuses on:</p> <ul style="list-style-type: none"> - Humanitarian work in response to crisis around the world - Improving children’s health and nutrition - Good quality education for children - Child protection to ensure children are safe and protected - Child rights governance - Advocacy for the rights and needs of children and to influence the policies and actions of governments - Reduce child poverty by lift families out of poverty
Swedish International Development Cooperation (Sida)	<p>Sida is a government agency working on behalf of the Swedish parliament and government, with the mission to reduce poverty in the world. Sida’s mission is to allocate aid and other funding. SRHR is therefore one of Sida's important profile issues. Sida provided funding to strengthen SRH and HIV prevention amongst children and young people through promoting comprehensive sexuality education in ESA</p>	DRC Ethiopia Kenya Mozambique Rwanda South Sudan Swaziland Uganda Tanzania Zambia Zimbabwe	<p>Sida’s work in ESA focuses on:</p> <ul style="list-style-type: none"> - Environment and climate - Gender equality - Defended human security and freedom from violence - Democracy, respect for human rights and freedom from oppression - Inclusive and sustainable economic development , including employment and decent work conditions - Health

¹¹⁴ Save the Children, 2014

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
			<ul style="list-style-type: none"> - Education and research - Humanitarian aid.
USAID	<p>USAID is the lead U.S. Government agency that works to end extreme global poverty and enable resilient, democratic societies to realize their potential.</p> <p>USAID includes SRHR within its priority programme areas</p>	<p>Angola Botswana Burundi Democratic Republic of the Congo Ethiopia Kenya Lesotho Madagascar Malawi Mozambique Namibia Rwanda South Africa South Sudan Swaziland Tanzania Uganda Zambia Zimbabwe</p>	<p>USAID programs that address reproductive health include:</p> <ul style="list-style-type: none"> - Child Marriage - Family Planning - Female Genital Mutilation/Cutting - Fistula Prevention - Gender-Based Violence - HIV and AIDS - Maternal Health - Post abortion Care
UNAIDS	<p>UNAIDS serves as the leading advocate for global action against HIV/AIDS. Its mission is to guide, strengthen and support worldwide efforts to turn the tide against the epidemic.</p> <p>UNAIDS focuses on:</p> <ul style="list-style-type: none"> - preventing the spread of HIV; - providing care and support for those infected and affected by the disease; 	<p>Angola Botswana Comoros Eritrea Ethiopia Kenya Lesotho Madagascar Malawi Mauritius Mozambique Namibia</p>	<p>In recognition of the global movement to influence national positions and political will and to inspire action towards achieving the SRHR goal, UNAIDS in collaboration with other agencies convened a meeting comprising of 40 organizations working on women’s rights, SRHR, lesbian, gay, bisexual, transgender, and intersex issues, and youth and HIV.</p> <p>UNAIDS Disability and HIV Policy Brief (2009) recognizes the relationship between HIV/AIDS and</p>

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
	<ul style="list-style-type: none"> - reducing the vulnerability of individuals and communities to HIV/AIDS; and - Easing the socio-economic and human impact of the epidemic. 	Rwanda Seychelles South Africa South Sudan Swaziland Uganda United Republic of Tanzania Zambia Zimbabwe	disability and stresses the importance of addressing both areas in an integrated fashion ¹¹⁵ .
UNDP	UNDP helps to achieve the eradication of poverty, and the reduction of inequalities and exclusion.	Angola Botswana Burundi DRC Comoros Eritrea Ethiopia Kenya Lesotho Madagascar Malawi Mauritius & Seychelles Mozambique Namibia Rwanda South Africa South Sudan Swaziland Uganda Tanzania Zambia Zimbabwe	UNDP: <ul style="list-style-type: none"> - Aims to eradicate poverty, violence and hunger, - Assists African countries to translate economic growth into long-lasting, inclusive and sustainable human development. - Helps countries to develop and share solutions to the challenges of poverty reduction and the achievement of the Millennium and Sustainable Development Goals, democratic governance , crisis prevention and recovery , environment and energy, and women’s empowerment.

¹¹⁵ UNAIDS/WHO/OHCHR, 2009

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
UNESCO	<p>UNESCO's mission is to contribute to the building of peace, the eradication of poverty, sustainable development and intercultural dialogue through education, the sciences, culture, communication and information.</p> <p>UNESCO has identified Comprehensive Sexuality Education (CSE) as integral to its strategy on HIV and AIDS with a focus on HIV prevention, treatment, care and support for children and young people through in-school and out of school based responses. CSE is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information.</p>	<p>Focus countries include:</p> <p>Lesotho Malawi Namibia Mozambique South Sudan Tanzania Uganda Zambia</p> <p>Networking countries include:</p> <p>Angola Botswana Burundi Ethiopia Kenya Rwanda South Africa Swaziland Zimbabwe</p>	<p>UNESCO's focus includes:</p> <ul style="list-style-type: none"> - Building country capacity for effective and sustainable education responses to HIV; - Strengthening comprehensive HIV and sexuality education; and - Advancing gender equality and protecting human rights.
UNFPA	<p>UNFPA aims to deliver 'a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled'. In order to realise this goal UNFPA works to ensure that all people, especially women and young people, are able to access high quality sexual and reproductive health services, including family planning, so that they can make informed and voluntary choices about their sexual and reproductive lives.</p>	<p>Botswana Burundi Comoros Democratic Republic of Congo Eritrea Ethiopia Kenya Lesotho Madagascar Malawi Mozambique</p>	<p>The UNFPA's core mandate includes:</p> <ul style="list-style-type: none"> - Sexual and reproductive health - Family planning - HIV and AIDS - Maternal health - Midwifery - Obstetric fistula - Young people - Adolescent pregnancy - Child marriage

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
	<p>The organisation focuses on women and young people because these are groups whose ability to exercise their right to sexual and reproductive health is often compromised¹¹⁶.</p> <p>UNFPA also published a brief report on its work with partners at global and country levels on the promotion and protection of the rights of persons with disabilities. The organisation recognises that persons with disabilities have the same sexual and reproductive health (SRH) needs as other people. Yet they often face barriers to information and services.</p>	<p>Namibia Rwanda Seychelles South Africa South Sudan Swaziland Mauritius Tanzania Uganda Zambia Zimbabwe</p>	<ul style="list-style-type: none"> - Comprehensive sexuality education - Youth leadership and participation - Human rights and gender equality - Engaging men and boys - Female genital mutilation - Gender-based violence - Gender equality - Population matters - Census - Demographic dividend - Population trends
World Bank	<p>The World Bank is a vital source of financial and technical assistance to developing countries around the world. The World Bank Group has set two goals for the world to achieve by 2030:</p> <ul style="list-style-type: none"> — End extreme poverty by decreasing the percentage of people living on less than \$1.90 a day to no more than 3% — Promote shared prosperity by fostering the income growth of the bottom 40% for every country <p>In its 2007 Healthy Development strategy, the World Bank recognised that ensuring access to quality reproductive health and family planning services is fundamental to human development results.</p>	<p>Angola Botswana Burundi DRC Comoros Eritrea Ethiopia Kenya Lesotho Madagascar Malawi Mauritius Mozambique Namibia Rwanda South Africa South Sudan Swaziland</p>	<p>The World Bank intends to:</p> <ul style="list-style-type: none"> - improve the health of women, children and adolescents by: - Acting as an innovative financing pathfinder to accelerate the efforts to reach the 2030 goals for women’s, children’s, and adolescents’ health; - Financing high impact, evidence- and rights-based interventions to achieve measurable and equitable results; - Building inclusive, resilient systems and increasing domestic financing over time to sustain the gains and ensure that all women, children, and adolescents have access to essential healthcare, contributing to universal health coverage; and

¹¹⁶UNFPA, 2017

Organisation	Description	ESA countries operating in	SRHR and/or (Y)persons with disabilities programmes
	<p>The world Bank also acknowledges that including people with disabilities and expanding equitable opportunities is at the core of its work to build sustainable, inclusive communities, aligned with the institution's goals to end extreme poverty and promote shared prosperity.</p> <p>The Bank also integrates disability issues into its operations across a wide range of sectors, including promoting access to infrastructure facilities and social services, rehabilitation, skills development, creating economic opportunities, and working with disabled persons organizations, focusing on the most vulnerable among people with disabilities, such as women and children, and influencing policies and institutional development.</p>	Uganda Tanzania Zambia Zimbabwe	<ul style="list-style-type: none"> - Filling the financing gap by mobilizing additional resources from public and private sources, both domestic and international, and making more efficient use of existing resources.

5 Part 2 – Situational analysis

5.1 Framework of analysis

This section describes the framework used to guide the situational analysis.

5.1.1 WHO Six Building Blocks of a well-functioning health system

The WHO has developed a single framework that provides a clear definition of what makes up a health system in an effort to promote a standardized understanding of what constitutes a well-functioning health system.¹¹⁷ The framework constitutes of six pillars or ‘building blocks’ for an effective system: leadership and governance, financing, health workforce, information, medical products, vaccines and technologies and service delivery.¹¹⁸

Figure 5: The Six Building Blocks of a Health System

Pillar	Description
Leadership and governance	Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.
Financing	A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
Workforce	A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
Information	A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
Medical products, vaccines and technologies	A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
Service delivery	Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

¹¹⁷ WHO, 2007

¹¹⁸ WHO, 2007

5.1.2 Framework for the situational analysis

Ensuring access to SRHR to young persons with disabilities is not a health system issue alone; but rather requires a multi-sectoral response breaking socio-cultural, economic and structural barriers. It also requires empowerment of young persons with disabilities to claim their SRHR through education and information sharing, skills building, accommodation of disability and active inclusion and participation.

Particular responsibilities can be allocated to the education, health and justice sector. For instance the education sector needs to ensure that persons with and without disabilities understand their rights and the rights of others, both to be free from any form of discrimination, abuse, neglect and violence as well as the right to privacy, enjoyment of sexual life and building a family. The healthcare sector is responsible for providing SRHR services and programmes to respond to many SRHR needs. Where sexual and reproductive rights are contravened, the justice sector, including police and judicial services, must protect and bring justice. This includes the reasonable accommodation of persons with disabilities within the justice system. Other sectors, such as social welfare, community development, youth, and gender, are also important as part of a system to ensure young persons can fully realize their rights related to SRHR.

The six pillars of the effective healthcare system model provided by the WHO are pillars that, in their essence, relate to other sectors, including education and justice. For example, leadership and governance, financing (or funding), workforce and information are all arguably pillars of an effective education and justice system. Products and technologies and service delivery are more specific to the sector to which they relate but serve as general pillars for any sector.

This situational analysis therefore proposes to use the six pillars from the WHO health system model as pillars to structure the analysis of current access to SRHR services by young persons with disabilities in ESA. The analysis will consider the multi-sectoral response to ensuring access to SRHR under each of these pillars, not just the healthcare system response, but other sectors, including education and justice. To reflect the broadening of the framework beyond just the health care system, two changes are proposed:

- Terminology has been changed to reflect the multi-sectoral application of the model
- A seventh pillar has been added, 'legal and policy framework', to allow for analysis of the legislative and policy environment across ESA and ESA countries which support or inhibit access to SRHR services by young persons with disabilities.

There are similarities between the WHO system pillars and the framework provided in the WHO *Consolidated guideline on sexual and reproductive health and rights of women living with HIV*.¹¹⁹ This guideline structures its recommendations according to: enabling

¹¹⁹ WHO, 2017

environment; health interventions; service delivery; and research. A limitation of this guideline is that it takes a larger health focus and a secondary focus on education, and CSE in particular, and other sectors. Where the guideline provides relevant recommendations related to improving access to SRHR, these have been included in the relevant pillar (for example, in the guideline, many of the recommendations under 'creating an enabling environment' relate to legislation and policies, funding or workforce).

Figure 6: WHO Pillar Framework of Analysis



Each pillar of the framework is described in more detail in the table below.

**Table 4: The Pillars of the Framework of Analysis for young persons with disabilities
Access to SRHR**

Pillar	Description	
<p>Legal and Policy Framework</p>	<p>Legal and Policy Frameworks refers to the regulation which guides the environment in which young persons with disabilities exist and in which they access SRHR. It includes legislation and policies related to disability as well as SRHR (since these are rarely integrated in one legal or policy document).</p> <p>Regulation should directly provide for the rights of young persons with disabilities and their unique requirements in accessing SRHR.</p>	<p>Participation A critical aspect of the analysis is the inclusion of young persons with disabilities in all aspects of the framework. The level of young persons with disabilities’ participation underpins each pillar analysis.</p>
<p>Leadership and Governance</p>	<p>Leadership and governance is a broad concept which can include political will, public will, advocacy and communication. It also spans political, religious, business and civil society spheres and how they collaborate to promote and maintain inclusive access to SRHR services by young persons with disabilities.</p> <p>Effective leadership and governance in an environment where there is appropriate regulation, is integral to ensuring young persons with disabilities have access to SRHR services. Young persons with disabilities need to be represented in leadership and governance to ensure their needs are considered.</p>	
<p>Funding</p>	<p>Funding for young persons with disabilities to access SRHR could come from a variety of sources, including government funds, international donors and private spending.</p> <p>Adequate funding is required to ensure that the rights of this vulnerable population are upheld. Funding should be monitored to see if it reached young persons with disabilities. Special consideration needs to be given to the fact that the majority of young persons with disabilities are living in some of the poorest households in the region.</p>	
<p>Workforce</p>	<p>The workforce addressing access to SRHR for young persons with disabilities includes healthcare workers, social workers, teachers, relevant auxiliary workers and community workers.</p> <p>The presence of a well-trained SRHR workforce is imperative to the provision of services. The workforce needs to be trained to effectively communicate, and provide appropriate services to young persons with disabilities, including prevention and response services. Further to this, the sensitive nature of young persons with disabilities accessing SRHR needs to be addressed with the workforce to ensure that the workforce, itself, is not a barrier to access.</p>	

Knowledge Management	<p>Knowledge management includes effective use of monitoring and evaluation data obtained from countries and programmes. It also includes research conducted in the area and allowing for it to inform practice.</p> <p>Knowledge management is an essential component of any effective strategy for social change in order to understand the context of the situation, to direct and refine initiatives to enhance their effectiveness and efficiency and to ensure lessons are learned and programme and service delivery is based on evidence of what works.</p>	
Products, Technologies and Commodities	<p>Products, technologies and commodities span a variety of things required for young persons with disabilities to access SRHR, including assistive devices, HIV and STI prevention (condoms, PrEP) and treatment products, family planning and contraception. These should all be adaptable to suit the needs and capabilities of young persons with disabilities.</p> <p>Critically important is that young persons with disabilities gain equitable access to quality and affordable products, technologies and commodities.</p>	
Service Delivery and Programmes	<p>The design of services and programmes are important to ensure necessary results and impact are achieved, such as physical accessibility, social, religious and cultural barriers and challenges, social and behavioural change methods and the inclusion of young persons with disabilities in programme and service planning.</p> <p>Service delivery and programmes should be targeted to young persons with disabilities, either as part of mainstream programmes or as specific interventions, and address relevant issues that they face.</p>	

Within each of the seven pillars, the situational analysis considers how the regional response under each pillar recognise the rights of young persons with disabilities, as set out in the UNCRPD, and the factors within the pillar influence or impact access. For example, to what extent does the current workforce composition, skills, issues etc. affect young persons with disabilities access to SRHR services?

There are two principles which underpin the analysis in each of the seven pillars.

- *Participation and involvement of young persons with disabilities:* The UNCRPD obligates member states to ensure that young persons with disabilities have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them¹²⁰; and
- *Universal design and reasonable accommodation:* the UNCRPD requires member states to apply the concept of universal design when planning and providing services to persons with disabilities. Universal design means the design of products, environments, programmes and services to be usable by all people, to the greatest

¹²⁰ UNCRPD, 2006

extent possible, without the need for adaptation or specialized design¹²¹, which helps ensure persons with disabilities are included from the outset of programme, service and product design and can reduce stigma associated with differentiated approaches used for persons with disabilities. Where this is not possible services need to use 'reasonable accommodation' to provide access to services (e.g. Braille, SLI).

5.1.3 Integrating the frameworks

The pillar approach provides the primary lens through which this situational analysis attempts to consider the current state of access to SRHR services by young persons with disabilities, and the particular barriers and challenges to achieving access currently. The secondary lens through which the current response should be considered is provided by the socio-ecological model. This model requires us to consider the various levels of society that affect the ability of young persons with disabilities to access services, and the contextual factors that impact risk, vulnerability, access and participation.

The figure that follows offers an integrated view of the two models – the WHO pillars of identifying thematic areas and the socio-ecological model the level within the social system. Combining these two models provides a possible structure for analysing the current situation, a framework for identifying gaps and a basis for regional strategic planning. In practical terms, it requires each pillar to consider its ability to influence the intrapersonal, interpersonal, institutional, community and policy levels of improving access to SRHR services by young persons with disabilities. For example, an effective legal and policy framework response would ensure that young persons with disabilities are aware of their rights (intrapersonal), that they are protected from abuse or neglect by others (interpersonal), that institutions uphold and implement the laws and policies (institutional), that communities are aware of the rights of young persons with disabilities and their rights to SRHR services (community), and that all rights are reflected in the necessary legal and policy documents (public policy).

The integrated framework is illustrated in the figure below, with examples of the response within each pillar at each level of the socio-ecological model. These are examples for illustration and not comprehensive but provide a framework for considering the effectiveness of current responses and identification of gaps for future planning.

¹²¹ UNCRPD, 2006

Figure 7: Integrating the WHO pillar and socio-ecological models and examples of the necessary response

	1 Legal & policy framework	2 Leadership & governance	3 Funding	4 Workforce	5 Knowledge management	6 Products, technology & commodities	7 Service delivery & programmes
Intrapersonal	YPWD understand and exercise their rights with respect to access of SRHR services	YPWD are confident to take leadership and are able to represent a diverse group of PWD	YPWD can access resources and funding to develop their knowledge and skills and access services	YPWD are part of the health, education, and justice workforce	YPWD, community members and workforce know about the SRHR needs of YPWD	Products and technologies support agency and access to services of YPWD	YPWD can access all SRHR services and programmes (e.g. CSE, PrEP, Contraceptives, STI and HIV treatment)
Interpersonal	YPWD are equal sexual partners and are free of violence, abuse, neglect and exploitation	YPWD feel supported and represented by political and other leaders and participate as leaders	Funding supports positive intrapersonal relationships through increasing participation of YPWD	The health, education and justice workforce have positive attitudes and understand the rights of YPWD	There is knowledge on the interpersonal relationships of YPWD and how this leads to barriers in access	Products and technologies support interpersonal relationships including family and work	Services and programmes enhance interpersonal relationships by increasing awareness and understanding of rights
Institutional	Laws and policies are upheld and implemented by institutions, including health, education and justice institutions	Institutions are monitored and held accountable for implementing and upholding rights of YPWD	Institutions have sufficient funding to implement, govern and manage a coordinated response to access for YPWD	There is systemic training on the rights and needs of YPWD across institutional workforces	Institutions base their products, programmes and services on human rights principals and evidence of what works	Institutions promote and facilitate the use of products and technologies to support access	Institutions provide services and programmes using universal design and reasonable accommodation
Community	Rights of YPWD are understood and negative cultural, traditional and religious attitudes and practices are eliminated	Strong leadership of the rights of YPWD influences and informs how others treat YPWD	There is sufficient funding to supports community awareness efforts and access to SRHR within services	The health, education and justice workforce are ambassadors for the rights of YPWD in communities	Communities understand how attitudes and behaviours lead to barriers in access for YPWD	Products and technologies support community relationships including access to services	Services and programmes enhance community relationships by increasing awareness and understanding of rights
Policy	SRHR of YPWD are represented across national laws and policies	Laws and policies are monitored and leaders are held accountable for upholding the rights of YPWD	Laws, policies and strategies to realise the rights of YPWD are costed and funded	The workforce understands the legal and policy framework that supports the rights of YPWD	National laws and policies are based on evidence and good data on YPWD and their SRHR needs	Laws and policies promote and facilitate the use of products and technologies to support access	Services and programmes seek to implement the rights of YPWD set out in policies and laws

5.2 Legal and policy framework

This section discusses the international, regional and national legislative frameworks that are relevant to SRHR services for young persons with disabilities in ESA countries. According to the WHO, legislative and policy frameworks are important as they provide enforceable direction and requirements for programming and service delivery.¹²²

Across the 23 ESA countries there are a range of legal and policy documents which contribute to the legal framework surrounding young persons with disabilities and their access to SRHR. There are, however, no legal and policy documents which address the intersection of SRHR and young persons with disabilities. Rather, the legal framework provides for persons with disabilities, SRHR and youth separately. More recently, possibly arising as an outcome of the ESA Commitment, governments appear to be recognising and integrating SRHR of youth into national policies.

This section therefore looks first at disability legal and policy frameworks then SRHR frameworks. The section concludes with an analysis on the gaps in considering the intersectionality between young persons with disabilities and SRHR.

5.2.1 Disability frameworks

The majority of legal and policy frameworks relevant to ESA countries focus specifically on persons with disabilities, rather than specifically young persons with disabilities. To the extent that youth are specifically considered in the legal and policy frameworks for persons with disabilities, this is noted below.

5.2.1.1 International disability framework

The UNCRPD, and its Optional Protocol (2006), was the first international legally-binding human rights instrument to establish the minimum standards for the protection of a wide range of civil, cultural, political, social and economic rights of persons with disabilities.

The Convention follows the work of the UN in changing the attitudes and approaches to persons with disabilities. The Convention is intended as a human rights instrument with an explicit social development focus.¹²³ The UNCRPD describes a number of legal and policy obligations for member states, including the requirement to adopt appropriate legislative and administrative measures to ensure the rights recognised in the UNCRPD are implemented in a national context. Such measures include ensuring and promoting the full realisation of human rights and fundamental freedoms for persons with disabilities and abolishing any laws and regulations that constitute discrimination against persons with disabilities.¹²⁴

¹²² WHO, 2017

¹²³ UNCRPD, 2006

¹²⁴ UNCRPD, 2006

The UNCRPD specifically recognises the need for women- and child-focused legislation and policies to protect women and children with disabilities from exploitation, violence and abuse.¹²⁵

Eighteen of the 23 ESA countries have ratified the UNCRPD. Comoros and Madagascar have signed the Convention but not ratified it, which obligates them not to violate the objectives or purpose of the Convention but does not require them to uphold the specific obligations of the Convention. Botswana, Eritrea and South Sudan have not signed or ratified the Convention.

5.2.1.2 Regional disability frameworks: East Africa

The EAC has recognized the need to have a regional policy that is in line with the UNCRPD to promote and protect the rights of persons with disabilities in the region. The EAC has established the following regulatory instruments:

The Treaty for Establishment of the East African Community, 1999

The EAC Treaty establishes the EAC's recognition of the importance of addressing and responding to the challenges faced by persons with disabilities in the region.¹²⁶ The Treaty calls for the EAC Partner States to "closely cooperate in the field of social welfare with respect to, among others, the development and adoption of a common approach towards the disadvantaged and marginalised groups, including children, the youth, the elderly and persons with disabilities through rehabilitation and provision of, among others, foster houses, healthcare, education and training."¹²⁷

EAC Policy on Persons with Disabilities, 2012

The purpose of this policy is 'to provide an enabling environment for the empowerment of persons with disabilities to enable them to effectively participate in and benefit from the development initiatives'. The policy seeks to provide direction on improving the lives of persons with disabilities in the region by including disability in mainstream society development programmes. The policy aims to ensure that access to basic social services is mainstreamed through affirmative action by promoting access to quality healthcare including and reproductive health, based on a premise that persons with disabilities, rather than caregivers, should be able to make decisions that affect their lives.

EAC Strategic Plan for Gender, Youth, Children, Persons with Disability, Social Protection and Community Development, 2012 – 2016

¹²⁵ UNCRPD, 2006

¹²⁶ EAC, 2012

¹²⁷ EAC, 2012

The EAC strategic plan was developed to comply with and give direction to implementation of the EAC Treaty. The strategic plan recognises and seeks to address the challenges among different groups in accessing services, namely:

- Persons with disabilities accessing services, in particular reproductive health
- Youth accessing healthcare services, in particular reproductive health

The strategic plan recommends that countries establish policies and programmes to promote and protect the physical, mental and spiritual health of young people, with a particular focus on HIV/AIDS. With regards to persons with disabilities, the plan seeks to eliminate disparities in service provision and ensure relevant services are available to all citizens with disabilities. The plan also directly addresses the challenges faced by children and identifies children with disabilities as a particularly marginalised group but does not, however, provide specific recommendations on how to support this group. The strategic plan does not specifically consider young persons with disabilities in respect to accessing healthcare services or SRHR.

The strategic plan proposes a number of activities and one performance indicator specifically related to addressing the challenges of persons with disabilities in accessing SRHR:

Table 5: Activities and indicators related to young persons with disabilities and SRHR

Input	Description
Indicator	Access (by persons with disabilities) to basic rights and social services, especially shelter, health, education, employment, microfinance and public information by 2016
Activities	<ul style="list-style-type: none"> - Conduct surveys and research including collection of disaggregated data on issues of persons with disabilities - Develop a guideline for equipping service providers with disability-friendly skills and knowledge for effective service delivery and management - Develop standard guidelines for service delivery to persons with disabilities in the EAC

Source: EAC, 2012

The indicator and selected activities listed above are relevant to the issue of persons with disabilities accessing SRHR. However, the activities are very general and may not address the specific needs or experiences of young persons with disabilities or specifically how young persons with disabilities access SRHR. The indicator did not provide a baseline or target or clarity on how it would be measured.

The strategic plan includes a breakdown of indicative budgets for each component of the plan. The total budget of USD 3,450,000 is divided between the different components.¹²⁸

¹²⁸ Components of the plan include: 1. Gender and women in socio-economic development 2. Youth empowerment 3. Child protection and development 4. Persons with disabilities 5. Social protection 6. Community development and 7. Participation of citizenry

'Persons with disabilities', together with 'social protection' and 'participation of citizenry', are allocated the lowest share of the budget. 'Youth empowerment' is allocated the largest portion of the plans budget, however none of the youth empowerment activities specifically consider young persons with disabilities.

5.2.1.3 Regional disability frameworks: Southern Africa

The Southern African Development has adopted the International conventions that relate to the promotion of the rights people with disabilities, but in addition to these SADC member states has developed and adopted policies and frameworks that include specific mention of the rights of persons with disabilities. These frameworks include:

Treaty of the Southern African Development Community, 1992 (amended 2001)

The SADC treaty established the principles, objectives and general undertakings of the SADC member states. The Treaty prohibits the discrimination of person under any grounds including disability.¹²⁹

SADC Protocol on Gender and Development, 2008

According to this policy, SADC member states shall endeavor to protect gender equality and equity rights and to implement legislative measures to protect the constitutional and legal rights of individuals. Article 9 of this policy deals specifically with persons with disabilities, stating that in conjunction with the SADC Health Protocol, member states shall adopt legislation and related measures to protect persons with disabilities taking into account their individual vulnerabilities.

Protocol on Health in the Southern African Development Community, 1999

The SADC Health Protocol aims to promote health care for all through better access to health services. In Article 15 of the Protocol, it establishes that state parties shall co-operate and assist one another to:

- promote effective measures to prevent and manage disabilities
- increase access to improved technology related to assistive devices and the creation of a barrier free environment and to afford equal opportunities for persons with disabilities

Member states are also required to formulate coherent, comparable, harmonized policies and programmes for reproductive health particularly in the reduction of genetic and congenital disorders leading to birth defects and empowering communities and women to access safe, effective and affordable methods for regulating fertility.

The Charter on Fundamental Social Rights in SADC, 2006

¹²⁹ SADC, 2001

The Charter contains provisions relating to disability that will create an enabling environment such that all persons with disabilities shall be entitled to additional concrete measures to improve their social and professional integration. The Charter states that the measures shall relate to, in particular vocational training, accessibility and mobility according to the capacities of the beneficiaries.

5.2.1.4 Regional disability frameworks: ESA

The regional legal and policy frameworks which are most specific and relevant to how young persons with disabilities access SRHR are described above. A number of other regional frameworks are relevant, but not specific, to how young persons with disabilities access SRHR. These frameworks provide a supportive environment for pursuing increased access to services. These frameworks include:

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- The African Women's Protocol to the African Charter on Human and People's Rights (2003)
- The Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Plan of Action on Sexual and Reproductive Health and Rights (2006)
- African Youth Charter (2006)
- General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012)
- The ESA commitment made by ministers of Health and Education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for adolescents and young people (2013)
- General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)

5.2.1.5 National disability frameworks

Table 6: National Disability Frameworks

Country	Name of Document	Relevance to disability
Angola	The Constitution of Angola, 2010	Article 23: recognises the right of all citizens to be equal before the laws Article 83: set concrete and clear protection measures to ensure and promote the rights of persons with disabilities Article 77: deals with broad social rights and promotes necessary measures to secure that all the rights to medical assistance as well as the right to child care and in the situation of incapacity, work in terms of the law
Botswana	Botswana Constitution, 1966	Does not expressly prohibit discrimination on the basis of disability Mentions that all people are equal before the laws but does not directly express that persons with disabilities have specific rights and needs
	National Policy on Care for People with Disabilities, 1996	Serves as a provision for guidelines and establishments of responsibilities for the various bodies involved in caring for PWDs State to mandate the following: prevention of the social, emotional and physical deprivation of PWDs; maintenance on a system of care for people with disabilities; ensuring that the welfare of people with disabilities has its rightful place in development programmes in the broad education, health, social, physical and economic spheres; as well as to ensure that people with disabilities are not disadvantaged in securing employment whenever possible. The Policy also fails to include the provision of better access to public facilities and transportation for people with disabilities. This is discriminatory practice in terms of Article 2 of the UNCRPD ¹³⁰
	Inclusive Education Policy, 2011	Ensures accessibility and equitability in education for all including PWDs. Provides children, young people and adults with access to relevant, high quality education which enabling them to learn effectively, whatever their disability or capacity ¹³¹
	Children's Act 2007	Provides that parents, guardians and other persons shall give the child with disabilities care and ensure the dignity of the child, promote the child's self-esteem and enable the child to proactively participate in social, cultural and educational activities. ¹³²
Burundi	Burundi's Constitution of 2005	Prohibits any form of discrimination and places specific emphasis on promoting equal opportunities for all

¹³⁰ UNCRPD, 2006

¹³¹ University of Pretoria, 2014

¹³² Constitution of Botswana, 1966

Country	Name of Document	Relevance to disability
Comoros	Comoros Constitution of 2001 (through 2009 amendments)	Does not provide for any enforceable law on the discrimination and has no provisions for the discrimination of vulnerable groups such as persons with disabilities. This is a contravention of the UNCRPD Article 2.
Democratic Republic of Congo	Congo (Democratic Republic of the)'s Constitution of 2005 with amendments through 2011	The Congo has does not directly address issues related to disability. The Constitution provides broadly that 'handicapped persons have the right of access to specific measures of protection concerning their physical, intellectual and moral needs'. It also provides that the State has 'the duty to promote the presence of handicapped persons within the national, provincial and local institutions" ¹³³ Article 44 that all persons have access to establishments of national education without discrimination of their physical, mental or sensorial state in accordance with their capabilities and provides under Article 66 of the documents prohibits the discrimination of fellow citizens by other Congolese nationals. ¹³⁴
Eritrea	Goods for the Disabled Government Assistance Regulation, 2004	Objective of the regulation is to provide full or partial government assistance to persons with disabilities with respect to customs duties on imported goods specifically designed for their use.
	The Constitution of Eritrea, 1997	Its article 14 prohibits discrimination of persons on the ground of their disability by including 'disability' amongst the list of prohibited factors against discrimination.
	Transitional Civil Code of 1991:	Lays down the rights, powers and limitations of insane, infirm and judicially interdicted persons. Disabled persons may be within the ambit of this code.
	Labour Proclamation No 118/2001	Articles 63 and 64 of the Labour Proclamation aim to regulate the working conditions of PWD. Article 64(1) further prohibits discrimination of PWD on the ground of their disability in cases of employment opportunities, treatment and employment remuneration

¹³³ The Constitution of the Democratic Republic of the Congo, 2005

¹³⁴ The Constitution of the Democratic Republic of the Congo, 2005

Country	Name of Document	Relevance to disability
	Transitional Penal Code of Eritrea (1991)	<p>According to article 48 of the Penal Code, a person is not criminally 'responsible for his acts when, owing to age, abnormal or deficient condition was not, at the time of his act, fully capable of understanding the nature and consequences thereof ...'</p> <p>Articles 133-137 of the Code also contain provisions concerning confinement and treatment of offenders with mental illness or impairments.</p> <p>Article 559 of the Penal Code stipulates that an abduction of an 'insane, idiot or feeble-minded woman' is an offence and is punishable with rigorous imprisonment not exceeding five years. Also, article 591(1) of the Code stipulates that sexual intercourse or any other indecent act with an 'idiot, a feeble-minded, or insane person' is punishable with rigorous imprisonment</p> <ul style="list-style-type: none"> Note here the inappropriate terminologies used under articles 559 and 591 of the Transitional Penal Code in the above relating to persons with disabilities.
	National Health Policy, 2010	Provides for a rehabilitative health care and gives strategic directions to strengthen this health care by undertaking preventative and rehabilitative interventions to reduce disabilities caused by injuries.
Ethiopia	The Constitution, 1994	Provides for the right to rehabilitation for people with disabilities and mandates that "the State shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardians"
	Proclamation No. 568/2008 deals with the Rights to Employment for Persons with Disabilities	This proclamation prohibits workplace discrimination and promotes equally employment opportunities for persons with disabilities. Encourages the employment of women with disabilities; and facilitate persons with disabilities to execute work or follow training with aid of an assistant when necessary. ¹³⁵
	The Federal Civil Servant Proclamation No. 515/, 2007	This proclamation is directed to government officials only. The proclamation affords special recruitment promotion, and deployment preferences, among others to qualified disabled candidates. ¹³⁶
	Proclamation on Definition of Powers of Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia, No. 691/2010	The proclamation provides for equal opportunities and full participation of persons with disabilities and those living with HIV/AIDS. ¹³⁷

¹³⁵ The Constitution of the Democratic Republic of the Congo, 2005

¹³⁶ ILO, 2013

¹³⁷ ILO, 2013

Country	Name of Document	Relevance to disability
	Growth and Transformation Plan (GTP) 2010-2015	Recognises disability as cross-dimensional development issue. The plan focuses on education and training, rehabilitation and equal access to services and opportunities for persons with disabilities, as well as strategies to prevent disability. ¹³⁸
	The National Plan of Action for the Inclusion of Persons with Disabilities (2012 – 2021)	A policy framework purposing to create an inclusive society by incorporating disability issues across all sectors of society in Ethiopia. ¹³⁹ The plan provides for 'comprehensive rehabilitation services, equal opportunities for persons with disabilities in education, skills training and work, as well as full participation in the lives of their families, communities and the nation'. ¹⁴⁰
	The Developmental Social Welfare Policy of 1997	Alluded to the 'inclusion, participation and independence of persons with disabilities, including children. Implementation strategies include creating accessible physical environments, promoting positive attitudes towards disability, and assisting NGOs working on the issue'. ¹⁴¹
Kenya	The Persons with Disabilities Act 14 of 2003	Provide for the rights and rehabilitation of persons with disabilities and to achieve equalisation of opportunities for persons with disabilities. The Act also purposes the establishment of the National Council for Persons with Disabilities (NCPWD).
	The Basic Education Act 14 of 2013	Part VI of the Act focuses on promotion of special needs education and the establishment and management of special institutions. Under the Act, children with special needs are identified as including 'intellectually, mentally, physically, visually, emotionally challenged or hearing impaired learners, pupils with multiple disabilities and specially gifted and talented pupils'. ¹⁴²
	The Children's Act 8 of 2001:	The Children's Act explicitly prohibits discrimination against a child on the ground of disability under Section 5. Section 107(2) of the Act provides for the extension of guardianship when a child suffers from a mental or physical disability or illness rendering him or her incapable of maintaining himself or herself or managing his own affairs and property without a guardian's assistance ⁷ .

¹³⁸ SIDA, 2014a

¹³⁹ ILO, 2013

¹⁴⁰ SIDA, 2014a

¹⁴¹ SIDA, 2014a

¹⁴² University of Pretoria, 2014

Country	Name of Document	Relevance to disability
	National Disability Policy of 2006:	Recognises disability as a 'human rights and a development phenomenon that cuts across all aspects and spheres of society and which requires support from all sectors' and The Policy reverberates the rights of persons with disabilities to accessibility, education and employment. ¹⁴³
	Kenya Aids Strategic Framework 2014/2015 – 2018/2019 (KASF)	The Kenya (KASF) 2014/15-2018/19, is the Strategic guide for the country's response to HIV at both national and county levels. The KASF 2014-2019 is premised on the KNASP III that concluded in 2014 and builds on the achievements, partnerships, leadership and legislation established in previous KNASP and strategies. The KASF employs a co-ordinated, multi-sectoral response to HIV and AIDS through strategic policy, planning and implementation guidance and leadership. KASF has also mainstreamed gender and human rights in all aspects of the response planning and service delivery.
Lesotho	Children's Protection and Welfare Act 2011 In Lesotho, the Disability Equity Bill was enacted in 2014. In addition to the establishment of Disability Advisory Council, the Bill makes provisions for the legal rights of persons with disabilities by supporting the right to physical access, access to services (including health) and the provision of education. ¹⁴⁴	Provides for the protection and promotion of rights of children living in Lesotho, including the rights of children with disabilities. Section 13 stipulates that children with disabilities have the right to dignity, special care, medical treatment, rehabilitation, family and personal integrity, sports and recreation. The act also seeks to ensure that children with disabilities enjoy a complete and decent quality of life and achieve the highest degree of self-reliance and social integration through the provision of adequate education and training. ¹⁴⁵
	Section 3 under the Sexual Offences Act 2003	Employs that it is an offence for persons to engage in sexual intercourse with a persons with disabilities, who does not have the capacity to consent to such an act. ¹⁴⁶

¹⁴³ University of Pretoria, 2014

¹⁴⁴ Matsoha – Makhoali, 2015

¹⁴⁵ Shale, 2015

¹⁴⁶ Kotzé, 2012

Country	Name of Document	Relevance to disability
	National Strategic Development Plan (NSDP) 2012/13-2016/17.	The plan sets out that government has a responsibility to implement strategic measures to stimulate the well-being of persons with disabilities in the country. It provides accountability measures for the provision of suitable access to quality health services for persons with disabilities; preventing disability through provision of quality health services; admission into formal and non-formal education institutions; growing the number of teachers skilled in the education of children with disabilities; improving employment opportunities for PWDs; ensuring accessibility of public buildings, roads and other social services; and lastly reviewing the disability grant policy for purposes of enhancing the lives of the beneficiaries. ¹⁴⁷
	The National Disability and Rehabilitation Policy (NDRP) 2011	Acts as a guiding framework for government programmes and interventions specifically intended to address disability. The policy advocates for the inclusion of people with disabilities across various sectors including education, health, accessibility, employment, and social services. The policy is required to be employed by all the ministries in the Lesotho government, while the lead ministry for disability is responsible for coordinating the implementation of the policy. ¹⁴⁸
	Draft National Disability Mainstreaming Plan 2015	Ensures the mainstreaming of disability in all Government Ministries. Despite the Government of Lesotho making noteworthy legal and policy provisions aimed at promoting and protecting the rights of persons with disabilities in the country, there are still some areas of Lesotho's legal framework which remain discriminatory towards PWDs: According to Section 57 of the Constitution of Lesotho, people unable speak are not authorised to be appointed as senators. This is a constitutional prohibition for mute person from being appointed in the Upper House exclusively based on disability. This condition is based on the cultural belief held by the people of Lesotho (Basotho) asserting that Deaf people should be excluded from participating in national issues on the basis of their disability. ¹⁴⁹
Madagascar	Law No. 97-044 of 19 December 1997	This law on jobs and social protection was considered a milestone in Madagascar as it established a foundation for other legal documents on the rights of people with disabilities. The law provisions for the rights of people with disabilities to health, education, training and

¹⁴⁷ Kotzé, 2012

¹⁴⁸ Kotzé, 2012

¹⁴⁹ Matsoha – Makhoali, 2015

Country	Name of Document	Relevance to disability
	Decree No. 2001-162 was adopted on 21 February 2001	Chapter 2, article 17 – article 25 in the Decree stipulates that children and young people with disabilities have the right to education in mainstream schools, and depending on the severity of the disability be accommodated in specialised schools. ¹⁵⁰ Article 12 emphasises that physically and sensory-impaired children should be allowed equal access to all levels of the education system. The decree also sets out standards for infrastructure requirements. The decree also recognises the need to train specialised teachers to ensure quality education for children with disabilities and therefore proposes the inclusion of specific modules in the curricula for pre-service training of teachers. ¹⁵⁰
	Decree No. 2009-1147, adopted 2009	Provides a definition of inclusive education, specifically targeting children in vulnerable or marginalised households, including children with disabilities. The Title I of the decree emphasises the rights of these children under age 16 to education in mainstream schools. Decree outlines the intention and function of inclusive education, the responsibility of MEN, the targeted groups of children, and the different actors in play (including local authorities, NGOs, religious communities, charity groups, health personnel, social workers etc.). ¹⁵¹
Malawi	The Malawi Disability Act	Act provides for the right to healthcare; education and training; employment; social protection; accessibility; accessibility; association and representation; cultural and sporting activities, and recreational services; participation in political and public life; housing; and information and communication technologies (ICT). ¹⁵²
	The National Policy on Equalization of Opportunities for Persons with Disabilities 2006	The primary objective of the act is “to integrate fully people with disabilities in all aspects of life thereby to equalize their opportunities in order to enhance their dignity and well-being so that they have essentials of life”. The policy recognizes “that to compete favourably, people with disabilities should have equal access to education, training, employment, health and other aspects of life”.
	Special Needs Education (SNE) Policy, 2007	The policy prioritises the learners with special education needs (SEN) and therefore provides for education and training; equitable access; educational facilities equipped with supportive amenities; an inclusive learning environments for all learners with SEN. The policy also provisions for the improvement of SNE services provisions. ¹⁵³
Mauritius	Constitution of Mauritius	Provides that no person shall be subject to discrimination on the basis of disability

¹⁵⁰ Education Development Trust, 2016

¹⁵¹ Education Development Trust, 2016

¹⁵² Chilemba, 2015

¹⁵³ University of Pretoria, 2014

Country	Name of Document	Relevance to disability
	National Policy Paper and Action Plan on Disability	The Policy outlines a Disability unit within which issues regarding persons with disabilities are addressed. The National Council for the Rehabilitation of persons with disability and the training and employment of disabled person's board. The Policy also highlights the context of disability in Mauritius. The policy also lists the National action plans and recommendations that will address issues of persons with disabilities
	National Youth Policy , 2016	The Policy holds a non-discriminatory approach where no distinction is made in youth programmes against youth on the basis of disability and sexual orientation The Policy also provides that the responsibilities of the private sector are to recognise the right of the disabled. ¹⁵⁴
Mozambique	Constitution of the Republic of Mozambique, 1990	Provides that the State shall ensure the special protection of those who are disabled in the national liberation struggle. It also provides that the State shall ensure the protection of those who were disabled in the armed conflict Also provides that disabled citizens shall enjoy the full rights of the Constitution. It also states that all citizens have the right to assistance in the case of disability and the state shall promote and encourage the creation of conditions of realising this right. The Constitution provides that children, disabled and orphaned in particular shall be protected from all forms of discrimination. The disabled shall have a right to protection by the family, society and State. The state shall promote the creation of conditions necessary for the economic and social integration of the disabled. The State shall coordinate with associations of the disabled to promote a policy that will guarantee the rehabilitation and integration of the disabled and access to public areas among others. ¹⁵⁵
	The Disability Policy of 1999	This policy outlines some specific rights for people with disabilities, including but not limited to the right to independent living; the right to integration in the family and community; the right to rehabilitation and access to compensation means; the right to formal, special or vocational education; the right to employment; and the right to social protection. ¹⁵⁶
	The National Action Plan on Disability (PNAD: 2012 – 2019)	An action plan to improve the quality of life of the disabled. This plan is informed by various national and international instruments and inputs from all stakeholders. The plan is implemented by the National Disability Council. All ministries have the responsibility to develop their own guidelines and activities according to PNAD. ¹⁵⁷

¹⁵⁴ Republic of Mauritius, Ministry of Youth and Sports, 2016

¹⁵⁵ Constitution of Mozambique, 2004

¹⁵⁶ Casimiro & Lopes, 2013

¹⁵⁷ SIDA, 2014b

Country	Name of Document	Relevance to disability
	Decree no 53/2008 of 30 December 2008	Regulates the construction and maintenance of technical accessibility, circulation and use of public service systems by people with disabilities. It approves the technical specifications on accessibility and the use of the International Symbol of Access. ¹⁵⁸
	Ministerial Diploma no 134/2010 of 19 August 2010	Assistance to demobilised combatants with a disability and their relatives or dependants. ¹⁵⁹
	Law no 6/92 of 6 May 1992:	This legislation redresses the general framework of the National Education System (NES) and enunciates the right of children with disabilities to education and foresees special classes of mainstream schools, ensuring the right of children with multiple disabilities or severe mental disorders to benefit from education tailored to their needs in a personalised manner. Article 29(3) of the legislation sets forth that vocational training shall be provided to children with disabilities in order to assist their integration into society and the labour market. ¹⁶⁰
	Law no 23/2007 of 21 August 2007	The Labour Law protects the rights of employees from disadvantaged groups, amongst others people with disabilities. ¹⁶¹
	Law 1 no 12/2009 of 12 March 2009	Establishes the rights and duties of persons living with HIV and AIDS, and takes measures necessary for the prevention, protection and treatment of the same and indicates that people with a disability have the right to be secured proper communication and civic education in the appropriate language or means taking into account their special needs. ¹⁶²

¹⁵⁸ SIDA, 2014b

¹⁵⁹ Casimiro & Lopes, 2013

¹⁶⁰ Casimiro & Lopes, 2013

¹⁶¹ Casimiro & Lopes, 2013

¹⁶² Casimiro & Lopes, 2013

Country	Name of Document	Relevance to disability
Namibia	National Disability Council Act 26 of 2004	This Act led to the establishment of the National Disability Council. Section 4(1) of this act stipulates that the Council has the authority and mandate to represent on behalf of any person with a disability before any organ of state, or provide or procure legal assistance for any persons with disabilities, if the matter in question relates to the rights of, or the integration of persons with disabilities in society ¹⁶³ . The Act also stipulates that the Government shall ensure that disability aspects are included in all relevant policy-making and national planning activities. The leading principle is that all persons with disabilities and their needs shall be incorporated into the general development plans and not be treated separately. ¹⁶⁴
	National Policy on Disability 2004	Was implemented with the mandate to support the objectives set out by the United Nations in the World Programme of Action Concerning Disabled Persons and The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities. The principle of which include participation, integration and equalisation of opportunities. ¹⁶⁵
	Sector Policy on Inclusive Education (2013)	This Policy was implemented by the Ministry of Education that seeks to provide access, equity and quality education to all children. Policy intends to establish an education system that inclusive, sensitive and responsive to the needs of all children, and ensures that all children receive education. The policy also focus on children and young people who have been, are, or are more likely to be, educationally marginalized, including children with disabilities. ¹⁶⁶
	Namibia Vision 2030	Sets out the policy framework for long-term national development. Part of its content refers to the importance of ensuring 'that people living with disability... are well integrated into the mainstream of society and have equal rights under the law', and recommends that PWDs are encouraged and assisted to participate actively in the economy and society. ¹⁶⁷
Rwanda	Law 1 2007: relating to protection of disabled persons in general:	This law related to the rights of disabled persons in Rwanda relating to education, health matters, employment, culture, entertainment, sport, transport, communication and access to infrastructure. This law is the premise for ensuring that every disabled person in Rwanda shall be entitled to equal rights as with other persons before the law. It states that "she or she shall be respected and entitled to human dignity".
	The Economic Development and Poverty Reduction Strategy II (2013-2018)	Includes equality and infrastructure for people with disabilities.

¹⁶³ Ntinda, 2013

¹⁶⁴ Namibia Statistics Agency, 2016

¹⁶⁵ Ntinda, 2013

¹⁶⁶ Republic of Namibia, Ministry of Education, 2013

¹⁶⁷ Kotzé, 2012

Country	Name of Document	Relevance to disability
	Constitution of Rwanda Articles 11, 14, 40	Article 41 states that all citizens have the right to health. This shows that the constitution of Rwanda has a basis for SRHR for young persons with disabilities. This also provides for the fact that the Rwandan government should be ensuring that there are SRH services and education for youth with disabilities.
Seychelles	Constitution of the Republic of Seychelles, 1993	The Constitution recognises that the right of the disabled to special protection undertakes the provision of improved quality of life and to promote programmes specifically that aim to achieve the greatest possible development of the disabled.
	Policy on Inclusive Education, 2015	The intention of the Policy is to address the barriers that have been preventing all learners from reaching their full potential and gives guidance on how this might be achieved and linked to other policies and supports a social model of disability
South Africa	The Constitution of the Republic of South Africa, 1996	States that "everyone is equal before the law and has the right to equal protection and benefit of the law". It thus guarantees the right of persons with disabilities to equality, non-discrimination and human dignity; and provides for the recognition of South African Sign Language as the first language of Deaf South Africans.
	The National Development Plan: 2030	Acknowledges that disabled people are excluded from opportunities available to other South Africans due to physical, information, communication and attitudinal barriers and states that and that 'Disability must be integrated into all facets of planning, recognising that there is no one-size-fits-all approach'.
	A White Paper on the Rights of Persons with Disabilities	It replaces and updates the 'Integrated National Disability Strategy (1997)', mentioned above. The White paper takes its cue from the South African Constitution as well as international legal framework, in particular the United Nations Convention on the Rights of Disabled Persons. The White paper aims to guide and prioritise actions which require coordinated action across a number of government departments, given the multi-contextual nature of the barriers confronted by people with disabilities. The White paper is a 'call to action' to government, civil society and the private sector, to work to inclusion of people with disabilities. The White Paper is likely to have a direct and indirect impacts on young persons with disabilities through its nine strategic pillars listed below. As highlighted above, successful implementation of this policy will lay the groundwork for the further prioritisation of young persons with disabilities and ways to increase access to SRH rights and services.
	Draft Bill on Social Development Services for People with Disabilities	Developed in 2015 with wide consultation across the disability sector
	Draft National Youth Policy (2014-2019)	Provides that all youth development initiatives should not discriminate against youth people on the basis of disability to endeavours to promote the interest generally of the youth, particularly young persons with disabilities.

Country	Name of Document	Relevance to disability
South Sudan	South Sudan's Constitution, 2011	The Constitution states that education is a right for every citizen and government shall provide access to education without discrimination as to disability It also provides that the state shall guarantee to persons with disabilities participation to society and the enjoyment of freedoms especially access to public facilities, education and employment
	Act on Welfare and Rehabilitation of Disabled Persons, 1984	Article 12 of this Act provides for the establishment of a fund for the welfare and rehabilitation of disabled persons to finance the activities undertaken in this field. It also provides for the setting up of a National Council to lay down general policy for the welfare of disabled persons and supervise regional councils in, what back then was, Sudan. The Act makes provision for measures to promote employment for disabled persons.
	Law Concerning the Privilege of War Disabled, 1998	People who have returned disabled from War or conflict form a significant part of the population. Having them recognised in a special law is important, as there still is a general stigma on disability in South Sudan – even though its rate of occurrence is evidently high in most kinds of communities. 2
Swaziland	The Constitution of the Kingdom of Swaziland Act, 2005.	Stresses a respect for the rights and dignity of persons with disabilities. Furthermore it highlights a commitment to enable persons with disabilities to reach their full mental and physical potential
	The Persons with Disabilities Bill, 2014	Advocates for the overall well-being of persons with disabilities in Swaziland. The Bill also mandates the establishment of a National Committee for Persons with Disabilities that is responsible for ensuring that all persons with disabilities have full and equal access and opportunities to education, health and other services at all levels; ensuring that all institutions provide services to persons with disabilities equivalent to those provided to the non-disabled, except where necessary; and promoting inclusiveness of persons with disabilities. ¹⁶⁸
	The 2013 National Disability Policy's	The Vision envisages a Swaziland where persons with disabilities have equal opportunities to participate freely as equal partners in society and be empowered to realise their full potential in all spheres of life without discrimination.
	National Development Strategy (NDS), 1997	Section 4.8.2.1 in the National Development Strategy (NDS), 1997 includes persons with disabilities amongst the 'disadvantaged groups' in Swaziland. This requires the government of Swaziland to adopt strategies which address issues of PWDs in Swaziland. Special Education and Accessibility within the NDS is a strategic that promotes the integration of persons with disabilities into the mainstream education system. ¹⁶⁹

¹⁶⁸ Kotzé, 2012

¹⁶⁹ Eide & Jele, 2011

Country	Name of Document	Relevance to disability
	National Education Policy, 1999	Is premised on the provision of opportunities for all pupils of school-going age and adults to develop themselves in order to improve the quality of their own lives and the standard of living of their communities. Section 5 of the Education Policy specifically addresses special needs. ¹⁷⁰ The policy adopts an inclusive education approach to children with disabilities including young persons with disabilities in mainstream school system
Tanzania	Persons with Disabilities Act 2010	The act serves the contemporary key legislation for disability in Country. Part 7 under this acts provisions for the substantive rights of healthcare, education, rehabilitation and employment for persons with disabilities in the country. ¹⁷¹
	National Policy on Disability 2004	Seeks to address these shortcomings, the government relating to issues of disabilities in the country. The policy provisions to empower persons with disabilities and their families, provide a conducive environment for them to participate in productive work, improve availability and access to services for persons with disabilities and ensure their involvement in all aspects of society including decision making. ¹⁷²
	Disabled Persons Employment Act No. 2 and the Disabled Persons Care and Maintenance Act No. 3	Both these acts purposed to secure employment for persons with disabilities using a quota system and retention of posts, while assigning specific responsibilities for care needs to government, families and civil society. Despite their promise, both the acts had a limited focus on employment and has largely failed in its implementation as they were neither effectively publicized nor enforced by the Tanzanian government. ¹⁷³
Uganda	The Constitution of Uganda, 1995	Article 21 prohibits discrimination against people with disabilities. Uganda is one of the few countries in the world to recognize sign language as an official language in its Constitution.
	Persons with Disabilities Act 2006:	The principal legislation focusing on disability in Uganda. Part 2 of this act provides for the rights to 'quality' education and health ¹⁷⁴ . As the primary legal instrument, this act serves to protect the human rights for persons with disabilities by eliminating of all forms of discrimination against persons with disabilities and provides for the equal access to opportunities. ¹⁷⁵

¹⁷⁰ Mavundla, 2015

¹⁷¹ Chilemba, 2015

¹⁷² Myamba et al, 2015

¹⁷³ Myamba et al, 2015

¹⁷⁴ Chilemba, 2015

¹⁷⁵ Oyaro, 2014

Country	Name of Document	Relevance to disability
	The Uganda National Policy on Disability 2006	Ensures that persons with disabilities are a core consideration and benefit from national interventions and programmes overseen by all government departments. The policy's primary focus areas include accessibility, participation, capacity building, awareness raising, prevention and management of disabilities, care and support, socioeconomic security, research, communication (sign language, tactile and Braille literacy) and budgeting. This policy also provides for the promotion and protection of the rights of persons with disabilities across various dimensions such as of health including HIV/AIDS interventions, education, social security, employment and access to basic human rights services for example access to justice. ¹⁷⁶
	National Council for Disability (Amendment) Act, 2015	The amendment provisions " <i>for the mode of electing members of the national council and the councils for disability at the village, parish or ward, sub-county or town, division, municipality or district; and to provide for related matters</i> ". ¹⁷⁷
	National Education Policy	Encourages equality for all in education related programming. ¹⁷⁸
	Universal Primary Education policy (UPE) and Universal Secondary Education policy (USE)	Provide that parents should give priority to CWDs and the girl-child, while enrolling their children in school ¹⁷⁹ . These policies provide free primary and secondary school education, significantly reducing the overall cost of education and therefore facilitating parents to send their children to school, including children with disabilities. ¹⁸⁰
	Universities and Other Tertiary Institutions Act,	As amended in 2006, provides for affirmative action during admission of persons with disabilities to public tertiary institutions.
	Equal Opportunities Commission Act, 2007	Mandated the established commission which was created in 2009 in Uganda. The Commission comprises of 5 member on which being a woman with a disability and functions to promote equal opportunities for marginalised groups, persons with disabilities included.
	Uganda National Institute of Special Education Act, 1998	Provides for the establishment of the Kyambogo National Institute of Special Education that is responsible for the training of teachers for children with special needs as well as special education teachers
	Employment Act, 2006 and Equal Opportunity Act, 2006	Provisions for the rights of all employees including persons with disabilities and prohibits discrimination of persons in work place based on disability.

¹⁷⁶ Oyaro, 2014

¹⁷⁷ National Council for Disability (Amendment) Act, 2015.

¹⁷⁸ Oyaro, 2014

¹⁷⁹ Beatrice, G., 2014

¹⁸⁰ ILO, 2009

Country	Name of Document	Relevance to disability
	Uganda Communications Act, 1998	Supports the promotion of research into the development and use of new communications techniques and technologies. The act also considers persons with disabilities and provides for communication design and development that promotes accessibility of hearing-impaired people to communication services
Zambia	Constitution of Zambia (amended), 2016	Principle the Constitution state that citizens shall subject to non-discrimination. It does not expressly name disability as grounds for discrimination but provides that disability is a may be a ground for discrimination
	Persons with disabilities Act, 2012	The Act provides the promotion and protection of rights of persons with disabilities through the provision of appropriate health services, education, employment, social protection and accessibility.
	National Youth Policy, 2006	The Policy promotes the development of all youth especially the target groups which include young persons with disabilities. The Policy aims to promote participation of young persons with disabilities by considering disability as a human rights issue.
	National Employment and Labour Market Policy, 2004	The Policy provides that social security should be provided to members to meet their basic needs as well as being protected from contingencies such as disability to enable them to maintain a standard of living equal to other citizens. The Policy also recognises the need to ensure that persons with disabilities have access to productive resources and aims to mainstream persons with disabilities in employment
Zimbabwe	Zimbabwe Constitution, 1980	One of the main highlights of the Zimbabwean Constitution is that it makes provision for persons with disabilities with both physical and mental disabilities. Within Section 22 of the constitution it is recognised that persons with disabilities have a right to be treated with respect and dignity and to realise their full potential. The constitution mandates the state to consider persons with disabilities within their developmental plans, encourage and develop forms of communication for persons with disabilities, foster DPOs. In Section 83 of the constitution outlines clauses around the full realisation of rights by persons with disabilities which includes several mandates for the state around persons with disabilities: to encourages their participation, fosters their self-reliance, protects persons with disabilities against exploitation, provide the necessary treatment, and provide special needs, state funded, educational facilities.
	Children's Act	The Act provides protection for children in terms of welfare and protects them from violations such as child labour, violence etc. the Act does not make reference to the rights of CWD as a vulnerable group and does not state the obligation to protect these children. ¹⁸¹
	Education Act	The Act guarantees the right to education for every child. There Act provides that there should be no discrimination in the education system between children on the grounds of race and gender, disability is not included in the list. ¹⁸²

¹⁸¹ Kotzé, 2012

¹⁸² Kotzé, 2012

Country	Name of Document	Relevance to disability
	Labour Act, 2002	Prescribes that the discrimination of persons with disabilities is strictly prohibited.
	The Disabled Persons Act (DPA) of 1992	This Act has led to the creation of the Office of Director for Disabled Persons' Affairs which ensures the implementation of policies and measures formulated by Zimbabwe's National Disability Board and coordinating activities of various DPOs within the Zimbabwean landscape. In addition the Disabled People's Act is the primary law that addresses disability in Zimbabwe. Though the current Act is under review and in the process of being updated. Currently the Act addresses the welfare and rehabilitation of persons with disabilities. It includes a non-discrimination clause which addresses discrimination in the workplace. In addition it makes it a criminal offence to deny persons with disabilities admission into any premises to which members of the public are ordinarily admitted or to deny provision of any public amenities. ¹⁸³ Though currently under review the old act has come under scrutiny for not being stringent enough. In one case it was reported that there is lee way for government buildings accessible to persons with disabilities though private buildings are strictly required to by law. ¹⁸⁴
	The Mental Health Act and the State Services (Disability Benefits) Act	The Mental Health Act provides more specified clauses that outline the care, detention, and after-care of persons with mental disabilities. The Act also established the creation of a Board whose responsibility is it to report on the condition of mental patients at mental health institutions. On the other hand, the State Services (Disability Benefits) Act provides for monitory compensation for government workers in particular government officials in the result of disability or death sustained in the course of duty. ¹⁸⁵ In 2013, the government of Zimbabwe also signed and ratified to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the optional protocol, the first international, legally binding treaty aimed at protecting the human rights of persons with disabilities. ¹⁸⁶

¹⁸³ Mandipa, E. & Manyatera, G., 2014.

¹⁸⁴ New Zimbabwe, 2017

¹⁸⁵ Mandipa, E. & Manyatera, G., 2014.

¹⁸⁶ SIDA, 2014c

5.2.2 SRHR frameworks

The following sections describe legal and policy frameworks related to access to SRHR services. In most instances, these instruments are not specific to young persons with disabilities although many do focus on young persons in general. The specific experience and challenges of young persons with disabilities in accessing SRHR services are therefore not necessarily considered or specifically supported by these frameworks.

5.2.2.1 International SRHR frameworks

There is no single international framework for SRHR, however specific and general SRHR issues are protected by the following frameworks:

- Universal Declaration of Human Rights (1948)
- International Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention of the Rights of the Child (1989)
- International Conference on Population and Development (1994)
- General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003)
- General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)
- Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014
- Joint General Recommendation No 31 of the Committee on the Elimination of Discrimination against Women/ General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014)

These international conventions and agreements, combined with international frameworks for persons with disabilities, create a basis for regional and national legal and policy frameworks to protect SRHR for young persons with disabilities.

5.2.2.2 Regional SRHR frameworks

Regionally there are a large number of legal and policy frameworks related to SRHR. This is in part due to the major focus on HIV/AIDS over the last decade, by ESA country governments and development partners alike.

There is a risk that these frameworks are heavily weighted towards issues of HIV/AIDS and focus on reducing and preventing HIV/AIDS and may overlook or be less complete regarding broader SRHR issues. However, these frameworks provide a good basis for efforts to strengthen SRHR for young persons with disabilities in the ESA region.

Table 7: Regional SRHR legal and policy frameworks

Input	Description
East Africa	<ul style="list-style-type: none"> • EAC Sexual and Reproductive Health Bill (2017) • EAC Policy on People with disabilities (2012) • EAC Regional Integrated Multisectoral HIV And Aids Strategic Plan: 2007 – 2012
Southern Africa	<ul style="list-style-type: none"> • Model Law on HIV in Southern Africa (2008) • The SADC Parliamentary Forum Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016) • Sexual and Reproductive Health Strategy for the SADC region (2006 – 2015) • SADC Protocol on Health, ratified in August 2004 • SADC HIV and AIDS Strategic Framework (2010-2015) • Recommendations by SADC Ministers of Health on strengthening Nutrition and Use of Traditional Herbal • Framework for Coordinating the National HIV and AIDS Response in the SADC Region (2005) to guide implementation of “Three Ones” • Framework for Advocacy on Challenges Facing PLWHA in SADC (2006) • SADC HIV and AIDS Surveillance framework (2008) • Harmonisation and Alignment framework for HIV and AIDS funding (2008) • SADC Business Plan on Orphans and other Vulnerable Children and Youth 2009-2015 • Sexual and Reproductive health Strategy (2008)¹⁸⁷
Africa	<ul style="list-style-type: none"> • Africa Union Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) 2009 • The Africa Union Continental Policy Framework on Sexual and Reproductive Health and Rights (2005) and the Maputo Plan of Action (2006)

¹⁸⁷ SADC HIV And Aids Strategic Framework, 2009

5.2.2.3 National SRHR frameworks, policies and plans

The table below summarises national SRHR frameworks, policies and plans to the extent they were available by desktop research. All countries in the ESA region have a national strategic plan (NSP) for HIV, which is not repeated in the table.

Table 8: National SRHR frameworks, policies and plans

Country	National SRHR frameworks, policies and plans
Angola	<p>Whilst policies and legislature pertaining to young persons with disabilities do exist in Angola, they have limited provision for SRHR requirements. However, the adoption of a new constitution in 2010 presents a possibility for these deficiencies to be addressed. The new constitution contains detailed provisions for the protection and rights of PWDs mentions PWDs and has specific clauses relating to anti-discrimination. A draft already exists for a law on social protection that addresses disability issues in detail, but this has remained in draft form for at least ten years¹⁸⁸. Angola has also signed the United Nations Convention on the Rights of Persons with Disabilities (CRPD), but there has been no formal endorsement of it yet. Currently no confirmed reports of strategic litigation based on disability rights is known to have occurred¹⁸⁸.</p> <p>The Sexual and Reproductive Health Strategy being developed by SADC countries, including Angola, provides a framework for developing reproductive health policies, and states that the sexual and reproductive needs of vulnerable groups, including people living with disabilities, will be promoted. It also states that service delivery for people with disabilities should be prioritised¹⁸⁹.</p> <p>The Angola 2005 National Youth Plan states that preventive medicine and the development of information measures and communication intended to disseminate knowledge about family life, gender, sexual and reproductive health is prioritised¹⁹⁰.</p>
Botswana	Policy guidelines and service standards for sexual and reproductive health
Burundi	Policies and legislature in Burundi do not have specific provision for SRHR for young persons with disabilities. Various laws and policies make reference to the broad delivery of health and social services for people in general.

¹⁸⁸ Kotzé, H. 2012.

¹⁸⁹ SADC, 2008.

¹⁹⁰ Youthpolicy.org. (2017).

Country	National SRHR frameworks, policies and plans
Comoros	<p>Legislation in the Comoros is not very inclusive of the rights and needs of persons with disabilities. The Comoros signed the Convention on the Rights of Persons with Disabilities on 26/7/2007¹⁹¹ however there aren't many policies available for review. Constitution: Specifically regarding SRHR, individuals have the right to decide the number, spacing, and timing of their children, manage their reproductive health and have access to the information and means to do so, free from discrimination, coercion, or violence. However, a general lack of health information and services for adolescent reproductive. No legal barriers prevent women from receiving treatment for sexually transmitted infections, but many hesitated to do so because of social and cultural concerns.¹⁹²</p>
Democratic Republic of Congo	<p>The DRC has signed a number of international conventions which indicate commitment towards advancing and improving the lives of persons with disabilities however the country has not developed its own set of policies and legislation to support and uphold the requirements of the conventions.</p> <p>Congo (Democratic Republic of the)'s Constitution of 2005 with amendments through 2011 There is no further information on the legislation promoting and protecting persons with disabilities that is publicly available.</p>
Eritrea	<p>Some of the policy documents in relation to sexual reproductive health in Eritrea are as highlighted below:</p> <p>Primary Health Policy: developed to ensure that primary healthcare is available to everyone¹⁹³</p> <p>Human Resource Development Policy: this policy is incorporated in the Primary Health Policy and it was intended to address training, planning and the management if healthcare workers¹⁹⁴</p> <p>Sexual and Reproductive Health Policy: this policy intends to ensure that each and every individual is able to access fully-integrated, quality sexual reproductive health services. These services can be accessed through governmental, NGO's or community-based health services.¹⁹⁵</p> <p>HIV/AIDS Policy: this policy provides the following</p> <ul style="list-style-type: none"> - guidelines on preventative activities - treatment and care - secures rights and dignity to people living HIV/AIDS¹⁹⁶

¹⁹¹ U.S. Department of State. (2011)

¹⁹² U.S. Department of State, 2011

¹⁹³ TASC ERITREA, 2004

¹⁹⁴ WHO, no date

¹⁹⁵ USAID, 2000

¹⁹⁶ TesfaNews, 2013

Country	National SRHR frameworks, policies and plans
Ethiopia	<p>In Ethiopia, whilst there are legislative and policy documents that address youth, SRHR and persons with disabilities separately, there are none which address them in combination. Some of the available legislations and policies in Ethiopia are summarised below: It outlines the States responsibilities regarding the provision of essential rehabilitation and the proper support services for person living with disabilities.¹⁹⁷</p> <p>The Reproductive Health Strategy (2006–2015) recognises the social and cultural influences on reproductive health in particular for women as one of its primary focuses. Other priorities under this strategy include fertility and family planning; maternal and new born health; HIV/AIDS; reproductive health of young people; and reproductive organ cancers.¹⁹⁸</p> <p>Despite many of the legislative and policy consideration for people with disabilities in Ethiopia, execution of such has been ineffective.¹⁹⁹ Poor coordination of international and domestic laws on disabilities lead to inefficiencies and gaps in implementation.</p>

¹⁹⁷ ILO, 2013

¹⁹⁸ Ministry of Health, 2006

¹⁹⁹ Yibeltal, K., 2013

Country	National SRHR frameworks, policies and plans
Kenya	<p>The Government of Kenya has adopted a number of laws and policies pertaining to people with disabilities, including their right to basic services. A summary of main legislation and policies are provided below:</p> <p>National Reproductive Health Policy 2007 Intended to improve the condition of reproductive health among all people in Kenya, National Reproductive Health Policy seeks to promote equitable access to reproductive health services and improve quality, efficiency and effectiveness of service delivery at all levels.²⁰⁰</p> <p>The Policy also purposes to ensure that the health services providers such as government, non-governmental organizations (NGOs), faith-based organizations (FBOs), community-based organizations (CBOs), private for-profit sectors and communities in Kenya have a common focus. Therefore the National Reproductive Health Policy functions to steer these service provider in terms of planning, standardisation, implementation, and monitoring and evaluation of reproductive health services.²⁰¹</p> <p>National Adolescent and Reproductive Health Development Policy (ARH&D Policy 2003 and 2015) Adolescent health and development issues are brought to the forefront of the national agenda by the Adolescent Reproductive Health and Development Policy. First introduced in 2003, this ground breaking policy serves as the first nationally implemented instrument that focuses on sexual and reproductive health and development concerns of Kenya’s adolescents.²⁰²</p> <p>Updated in 2015, the National ARH&D Policy works complementary to other health sector policies. The policy provides an in-depth review of the social, economic, cultural and demographic context of adolescent sexual and reproductive health in the country as well as exposes its implications and its consequences to adolescents’ health and development. Guided by this, the policy puts forward the structures and targets necessary to ensure that adolescent health concerns are mainstreamed in all planning activities²⁰³.</p> <p>Some of the priority strategic concerns addressed by the ARH&D Policy include: adolescent sexual and reproductive health and rights; harmful practices; drug and substance abuse; socio-economic factors; and adolescents and youth with disabilities.²⁰⁴</p> <p>Emphasising specifically on adolescents with disabilities, the policy takes cognisance of the SRH needs of adolescents with disabilities. The policy identifies that people with disabilities experience challenges with access to health services, and this has direct implications on their sexual and reproductive health.²⁰⁵ In response to this, the policy supports the provision of disability-friendly SRH information and services and ensures that adolescents with disabilities are included in data collection tools.²⁰⁶</p>

²⁰⁰ Republic of Kenya, Ministry of Health, 2007

²⁰¹ Republic of Kenya, Ministry of Health, 2007

²⁰² National Council for Population and Development, 2013.

²⁰³ Republic of Kenya, Ministry of Health, 2015

²⁰⁴ National Council of Population and Development, 2013.

²⁰⁵ Republic of Kenya, Ministry of Health, 2015

²⁰⁶ Republic of Kenya, Ministry of Health, 2015

Country	National SRHR frameworks, policies and plans
	<p data-bbox="504 311 1400 343">National Population Policy for Sustainable Development, No. 1 of 2000</p> <p data-bbox="504 343 2083 406">This policy outlines Kenya’s population and development goals, objectives and targets to guide its implementation between 2000 and 2010. The goals and objectives addressed in this policy include.²⁰⁷</p> <ol data-bbox="548 406 1926 598" style="list-style-type: none"> 1) improving the standard of living and quality of life of the people; 2) fully integrating population concerns into the development process; 3) motivating and encouraging Kenyans to adhere to responsible parenthood; 4) promoting the stability of the family; 5) empowering women and eliminating retrogressive sociocultural practices such as female genital mutilation; and 6) integrating the youth, the elderly and persons with disabilities into the mainstream of national development. <p data-bbox="504 598 2083 726">Persons with disabilities have been identified as a target population according to this policy. In this regard the policy seeks to promote and protect the rights of all persons with disabilities through the promotion of policies, programmes and strategies directed towards this realisation. Thus ensuring full participation of people with disabilities in all spheres of political, social, economic and cultural life.²⁰⁸</p> <p data-bbox="504 758 2083 861">The Kenya National AIDS Strategic Plan 2009/10 – 2012/13 (KNASP III) envisages ‘An HIV-free Society in Kenya’. The KNASP III recognises persons with disabilities as a vulnerable population who require effective interventions to prevent HIV transmission and promotes access to care and treatment.</p>

²⁰⁷ Republic of Kenya, Ministry of Finance and Planning, 2000

²⁰⁸ Republic of Kenya, Ministry of Finance and Planning, 2000

Country	National SRHR frameworks, policies and plans
Lesotho	<p>In Lesotho, there has been no legislation or policy which addresses SRHR for young persons with disabilities. There are however, policies which address SRHR and persons with disabilities separately. Young persons with disabilities still remain overlooked as a specific target and tend to be included as part of the overall target group of persons with disabilities. Some of the policy documents in relation to sexual reproductive health in Lesotho are listed below:</p> <p>Additionally, Section 219 of the Criminal Procedure and Evidence Act of 1981 provides that a Court of Law deems any evidence presented by persons with intellectual disability as unreliable and inadmissible based on the premise that they are of unsound mind. This makes persons with disabilities particularly vulnerable to sexual abuse. This provision is in contradiction of article 12 and 13 of the UNCRPD which requests government institutions to recognise the legal competency of people with intellectual disabilities in making sure that both civil and criminal justice of the state parties is accessible and inclusive of people with disabilities.²⁰⁹</p> <p>According to the Penal Code 2010, abortion is illegal in Lesotho. Section 45 (C) under this code does however, allow for 'abortion if the pregnant person should be giving birth to the seriously physically and mentally disabled child subject to the consensus of more than one medical practitioner'²¹⁰. (This provision has however become contentious amongst disabled activists who see this as discriminatory exclusion against children with disabilities being born²¹¹).</p> <p>National Adolescent Health Policy (2006) – this law protects health, development and right of adolescents²¹²</p> <p>PMTCT Guidelines (2007) – the guideline was launched in 2003 aimed at preventing HIV infection in pregnant woman; identifying pregnant woman who are infected with the virus; provision of effective interventions to reduce mother to child mother to child transmission of HIV (MTCT).²¹³</p> <p>Reproductive Health Policy (2009) – this policy commits to the achievement of integrating HIV/AIDS and SRH.²¹⁴</p> <p>The National AIDS Policy – this was developed in order to address the general and specific needs and gaps that were identified in the Lesotho's current policy and legislative framework at the National Joint Review. This policy provides comprehensive guidance to the implementation of the national HIV and AIDS response.²¹⁵</p> <p>National HIV/AIDS Strategic Plan for 2006-2011 – for a more coordinated and strategic approach, NSP was developed. NSP was developed with the aim of halting the epidemic and provide comprehensive care and support to the people who were already infected.²¹⁶</p> <p>The National HIV/AIDS Monitoring and Evaluation Plan – serves as an implementation plan for the National M&E framework.²¹⁷</p> <p>The National OVC Policy - the policy was developed to ensure the care and protection for vulnerable children.²¹⁸</p>

²⁰⁹ Matsoha – Makhoali, 2015

²¹⁰ Matsoha – Makhoali, 2015

²¹¹ Matsoha – Makhoali, 2015

²¹² HEARD, 2015

²¹³ Panos Institute Southern Africa, 2013

²¹⁴ HEARD, 2015

²¹⁵ Government of Lesotho, 2006.

²¹⁶ National AIDS Commission, Lesotho, 2006.

²¹⁷ National AIDS Commission, Lesotho, 2007.

²¹⁸ Government of Lesotho, Ministry of Health and Social Welfare, 2015

Country	National SRHR frameworks, policies and plans
Madagascar	<p>In Madagascar, the legal and policy framework for young persons with disabilities and that for SRHR, appears disintegrated. This is indicative of insufficient recognition of these two issues in a holistic manner. Whilst there are legislative and policy frameworks that address SRHR and persons with disabilities individually, there are none focus specifically on the access for young persons with disabilities to SRHR. Furthermore, although some of the frameworks provision for persons with disabilities, young persons with disabilities are often included as an overall target group of persons with disabilities with no separate mention.</p> <p>In relation to SRHR for young people, Madagascar has produced a National Strategic Plan to respond to HIV&AIDS and STIs from 2013 to 2017. Other policies and strategies referring to young people include the National Youth Policy, the National Policy on Adolescent Health, and the National Policy on Adolescent Reproductive Health and the Training Guide on Life Skills.</p>
Malawi	<p>In Malawi, whilst there are legislative and policy documents that address youth, SRHR and persons with disabilities separately, there are none which address them in combination. Some of the available legislations and policies in Malawi are summarised below:</p> <p>Malawi HIV/AIDS Policy 2003: recognizes the increased risk to HIV and AIDS experience by people with disabilities. Limited access to information often leaves persons with disabilities vulnerable to contracting HIV/AIDS. Women and girls among persons with disabilities are particularly susceptible to sexual abuse increasing their exposure to HIV/AIDS. The policy’s strategies therefore include: “increasing awareness on HIV/AIDS among various categories of persons with disabilities”, including by using DPOs; encouraging people with disabilities to get tested for HIV; and “promoting safer sexual and reproductive health practices among persons with disabilities”.²¹⁹</p> <p>The National Plan of Action for Scaling up Sexual and Reproductive Health and HIV Prevention Initiatives for Young People (2008-2012) combine all major HIV prevention initiatives for young people that are currently ongoing. The plan employs positive discrimination, in favour of social groups including young people with disabilities, youth living with HIV.</p> <p>Ministry of Youth and Sports: National Youth Policy 2013: The rationale for the adoption of the National Youth Policy seeks to provide ‘a framework with guidelines for the facilitation of meaningful youth development programs and services with full participation of the young people themselves at all levels’ (African Disability Rights Yearbook, 2014). Under this policy, social groups such young people with disabilities (young persons with disabilities) are targeted as priority groups. The overall policy objectives for young persons with disabilities include providing special training programmes and promoting youth friendly reproductive health services among all youth including youth with disabilities.²²⁰</p>

²¹⁹ International Labour Office, 2006

²²⁰ Republic of Malawi, Ministry of Youth and Sports, 2013.

Country	National SRHR frameworks, policies and plans
	<p>The National Sexual and Reproductive Health and Rights Policy (2009) recognises the need and importance of including issues such as basic emergency obstetric/neonatal care, cervical cancer screening, young people-friendly health services, antiretroviral therapy and prevention of mother-to-child transmission.²²¹</p> <p>National Sexual and Reproductive Health Program makes reference to the importance of Youth- friendly health services (YFHS) and a key focus within the program. The provision of YFHS contributes to achieving Malawi’s FP2020 commitment to achieve a 60 percent contraceptive prevalence rate, with a focused increase among those ages 15–24 years. Additionally, overseeing the functioning of the YFHS program in the country is one of the features safeguarding young people’s transition into adulthood and improving health indicators for 5 million people in Malawi.²²²</p>
Mauritius	<p>National Sexual and Reproductive Health Policy, 2007</p> <p>The Policy provides to ensure that SRH services are accessible to all people including adolescents and disabled persons.²²³ The Policy also provides that additional measures to implement programmes to monitor the intellectual development of children with physical and mental disability as well as to establish institutions to cater for handicapped children and to assist their parents.</p> <p>The Policy does not recognise young persons with disabilities as a vulnerable group which faces additional barriers to access SRH services.</p>

²²¹ Young People Today: Time to Act Now, no date

²²² USAID, 2015

²²³ Republic of Mauritius, Ministry of Health and Quality of Life, 2007

Country	National SRHR frameworks, policies and plans
Mozambique	<p>Some of the policy documents in relation to sexual and reproductive health in Mozambique are as highlighted below:</p> <p>Mozambique does not have a specific policy or legislation towards SRHR, however it is included in their constitution. According to the Constitution of Mozambique the following articles includes SRHR:²²⁴</p> <ul style="list-style-type: none"> – Article 36: this states that men and women shall be equal before the law in every sphere of political, economic, social and cultural life – Article 89: states that every citizen in Mozambique has the right to medical and health care services within the terms of the law – Article 116: this states that the all of the Mozambican medical and health care should be organised through National health system and it should benefit the citizens of Mozambique – Article 122: this addresses women’s development²²⁵ , “ <i>The State shall promote, support and value the development of women, and shall encourage their growing role in society, in all spheres of political, economic, social and cultural life of the country.</i>”²²⁶ <p>Unfortunately the constitution does not state whether the above articles also include people with disability.</p>
Namibia	<p>In Namibia whilst there are legislative and policy documents that address youth, SRHR and persons with disabilities separately, there are none which address them in combination. The policy available that refers to SRHR is listed below:</p> <p>National Policy for Reproductive Health (2001) seeks to ‘promote and protect the health of individuals and families through the provision of equitable, acceptable, accessible and affordable quality reproductive health services’.²²⁷ However this policy was regarded as outdated and does not respond to current trends and needs of the country.²²⁸</p>
Rwanda	<p>Adolescent sexual reproduction health and rights policy (2011-2015)</p> <p>Rwanda recognises Adolescent Reproductive Health (ARH) to be a right. As a result, at the International Conference on Population and Development (ICPD) in 1994 it signed an agreement committing to the Program of Action. This program includes the provision of sexual and reproductive health information, education, and services to adolescents.</p> <p>The formulation and development of the Adolescent Sexual and Reproductive Health Policy and Strategic Plan are key steps in the implementation of this commitment. These two documents are informed by the latest findings and recommendations in Rwanda concerning services and programs, in addition to those gathered from current literature from other countries. The documents reflect the urgent health needs and inadequate fulfilment of rights of young people in Rwanda. The Strategic Plan further details the proposed solutions to address these issues²²⁹.</p>
Seychelles	Not available in desktop review

²²⁴ Capana, 2016

²²⁵ Mozlegal, Lda, 1990

²²⁶ Mozlegal, Lda, 1990

²²⁷ Ministry of Health and Social Services, 2001

²²⁸ IPPF, UNFPA, WHO, UNAIDS, 2012

²²⁹ IPPF, UNFPA, WHO, UNAIDS, 2012

Country	National SRHR frameworks, policies and plans
South Africa	<p>The legal and policy framework for Youth, persons with disabilities and that for SRHR, remain relatively fragmented. That is, there are few, if any, pieces of legislation or policies directed specifically at access for young persons with disabilities to SRHR. This likely reflects insufficient prioritization of access to SRHR for young persons with disabilities, overall. There has, however, been important development in South Africa in each of these three frameworks separately, in the last ten years. All three populations and related legal and policy development mechanisms to prioritise their needs will need to be targeted for integrating issues related to access for young persons with disabilities to SRHR and services.</p> <p>Draft National Youth Policy 2014-2019 Priority 2 of the Policy is to develop innovative approaches to comprehensive SRHR information, education and information to adolescents. This includes developing appropriate devising effective communication mediums on ASRHR to adolescents with disabilities particularly in rural areas. The policy provides that there should be effective efforts to educate adolescents on their rights and responsibilities with regards to SRH.²³⁰</p>
South Sudan	<p>The National Reproductive Health Strategic Plan (2011 - 2015) is working to ensure youth and adolescents have access to quality and comprehensive youth friendly sexual and reproductive health services and education.</p>
Swaziland	<p>In Swaziland, the legal and policy framework for young persons with disabilities and that for SRHR remains distinctly separate. In other words, SRHR for young persons with disabilities, and their rights thereto, is not addressed specifically in Swaziland’s legal and policy framework. Furthermore, <i>young</i> people with disabilities, taking into consideration their own unique needs, are also not specifically addressed in the legislation.</p> <p>Legislation and policy related to SRHR and persons with disabilities in Swaziland are summarised below: Swaziland has an Education and Training Sector Policy, 2011 that makes provision for HIV and AIDS education. The policy recognises that in order to reduce the spread of HIV and AIDS and advocate for improved SRH in the country; education, health, social and legal systems must work collaboratively.²³¹</p>

²³⁰ Draft National Youth Policy, 2015

²³¹ Draft National Youth Policy, 2015

Country	National SRHR frameworks, policies and plans
Tanzania	<p>Whilst there are legislative and policy documents that address youth, SRHR and persons with disabilities separately, there are none which address them in combination. Some of the available legislations and policies in Tanzania are summarised below:</p> <p>The National Youth Development Policy, 2007 recognises the sexual and reproductive health and rights for young people in Tanzania. Additionally, the needs for young people with disability are featured in article 3.13 of the policy.²³²</p> <p>The National Adolescent Reproductive Health Strategy (2010-2015) functions as a framework for improving access to youth-friendly health services, information and education. In addition to this, the government of Tanzania has developed several policies and strategies including the Third National Multi-Sectoral Strategic Framework for HIV&AIDS (NMSF III; 2012/2013– 2017/2018) that is positioned to steer government’s cross-sectoral approach to dealing HIV and AIDS in the country.</p>
Uganda	<p>In Uganda, whilst there are legislative and policy documents that address youth, SRHR and persons with disabilities separately, there are none which address them in combination. Some of the policy documents in relation sexual and reproductive health in Uganda are as highlighted below:</p> <p>The NPD also sets the tone for the Second National Health Policy (NHP II) 2010. The NHP II primarily focus on the promotion of health, prevention of disease, early diagnosis and treatment of disease. Furthermore the policy endeavours to prioritise the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP).²³³</p> <p>The Uganda National Minimum Health Care Package (UNMHCP): in Uganda, service delivery for all levels of health system inclusive of both public and private sectors is directed by the UNMHCP. The UNMHCP is intended for all people in Uganda, with emphasis on vulnerable populations:²³⁴The four main categories of health services in the UNMHCP include the following:²³⁵</p> <ol style="list-style-type: none"> 1. Health promotion, environmental health, disease prevention, and community health initiatives, 2. including epidemic and disaster preparedness and response 3. Maternal and Child Health 4. Prevention, management, and control of communicable diseases 5. Prevention, management, and control of non-communicable diseases

²³² Key Informant Tanzania, 2016

²³³ Republic of Uganda, Ministry of Health, 2010

²³⁴ Republic of Uganda, Ministry of Health, 2010

²³⁵ Wright, J., 2015

Country	National SRHR frameworks, policies and plans
	<p>However, the Health Sector Strategic and Investment Plan 2010/11– 2014/15 identifies slightly different list of priorities categories for financial investment by the government and donors. These include:²³⁶</p> <ul style="list-style-type: none"> ● Sexual and reproductive health: in recognition of the slow progress being made toward attaining good health outcomes relating to this area of services ● Child health: in recognition of the need to accelerate implementation of cost-effective interventions to improve child health ● Health education: in recognition of the critical role that addressing health factors plays in attaining the overall health goals ● Control and prevention of communicable diseases (HIV, AIDS, malaria, and tuberculosis): in recognition of their major contribution to the overall disease burden. <p>In order to implement and operationalise the NHP II and the health sector component of the NDP in Uganda, the Health Sector Strategic Plan III (HSSP III) 2010/11-2014/15 was developed. As the overarching health sector framework, the HSSP III key purpose is to contribute towards the overall development goal of the Government of Uganda (GoU) of accelerating economic growth to reduce poverty as stated in the National Development Plan (NDP) 2010/11-2014/15.²³⁷The HSSP III also provisions for disability issues and one of the strategies and key interventions in this regard includes improving access to health services by people with disabilities.</p> <p>The National Adolescent Health Policy, 2004 provided key guidelines to address the needs and concerns of adolescents in Uganda. The main purpose of the policy is to underscore adolescent health concerns and ensure that it is incorporated into the national agenda in order to improve the quality of life and standard of living of young people in the country. Some of the objectives include:²³⁸</p> <ul style="list-style-type: none"> ● adopting a multi-sectoral approach to addressing the concerns of adolescent; ● encouraging meaningful participation and involvement of adolescents in the planning, implementation, monitoring and evaluation of adolescent health programmes; ● providing an enabling social and legal environment for the provision of good quality, accessible adolescent health interventions; ● training providers and reorienting the health system at all levels to better focus and meet the special needs of adolescents; ● using, promoting and disseminating relevant information to create awareness and influence behaviour across all sectors of society including individuals, communities, leaders and service providers regarding adolescent health; among others. <p>The policy also recognises challenges faced by young people with disabilities and identifies ‘adolescents with mental or physical disabilities’ priority beneficiaries. Some of the targets to monitor implementation of the policy includes accidents and disabilities and reproductive health. The policy establishes healthcare and education facilities as instrumental.²³⁹</p>

²³⁶ Wright, J., 2015.

²³⁷ Republic of Uganda, Ministry of Health, 2004

²³⁸ Republic of Uganda, Ministry of Health, 2004

²³⁹ Republic of Uganda Ministry of Health, 2004

Country	National SRHR frameworks, policies and plans
	<p>The National Policy Guidelines and Service Standards for Reproductive Health Services, 2001 seeks to provide a coherent and coordinated reproductive health programme and promotes increased availability and accessibility of SRH services to all including young people. The guidelines and standards in this policy are primarily informed by the goals and priorities contained with the framework of the National Health Policy. The policy purposes to improve the sexual and reproductive health of everyone in the country through:</p> <ul style="list-style-type: none"> • guided planning, implementation, monitoring and evaluation of quality integrated gender sensitive reproductive health services; • standardised the delivery of RH services; and • ensured optimum and efficient use of resources for the sustainability of RH services.²⁴⁰ <p>The policy also makes consideration for persons with disabilities and includes women with disabilities as part of the target and priority group for maternal services and adolescents with disabilities as part of the target and priority group for reproductive health service delivery²⁴¹.</p> <p>Third Edition Uganda HIV Counselling and Testing Policy, 2010 The overall goal of the HCT policy is to contribute to reduction of HIV transmission and improving the quality of life by enabling persons to know their sero-status and linking them to prevention, care, treatment and support services. The objective of the policy is:²⁴²</p> <ul style="list-style-type: none"> • to provide a framework for implementation and regulation of quality HCT services in Uganda; • to contribute to the strengthening of health systems for the provision of quality HCT services; and <p>to empower the community to access HCT services and adopt positive behaviour.</p>
Zambia	<p>Persons with Disabilities Act, 2012 The Act provides that the Minister shall take measures to ensure that persons with disabilities have access to health services and prescribe measures to ensure affordable health care and programmes including in the area of SRH²⁴³</p> <p>National Reproductive Health Policy 2008 The Country has a draft Reproductive Health Policy, 2000 however this Policy does not make any mention of persons with disabilities as a specific group with additional needs and fails to address SRHR for young persons with disabilities and persons with disabilities in general. The literature states that the revised Policy dated 2008²⁴⁴ has been developed but this was not available for review in the public domain.</p>

²⁴⁰ Republic of Uganda Ministry of Health, 2001

²⁴¹ Republic of Uganda Ministry of Health, 2001

²⁴² Republic of Uganda Ministry of Health, 2010

²⁴³ Zambia Persons with Disabilities Act [No.6 of 2012].

²⁴⁴ Ministry of Health, 2000

Country	National SRHR frameworks, policies and plans
Zimbabwe	<p>Additional legislation with mentioning that is relevant when considering the SRHR of CYPWD include:</p> <p>The National HIV/AIDS policy Year serves to direct programmes intended to combat HIV/AIDS in Zimbabwe. The policy also lead to the establishment of the National AIDS Council through an Act of Parliament.²⁴⁵</p> <p>National Youth policy in Zimbabwe functions to promote access to sexual and reproductive health information and services among the youth by encouraging all sectors of society including policy and decision-makers, communities, and health care providers to facilitate their access. The policy also stresses the provision of youth friendly services including reproductive health and youth counselling services and life-skills teaching/education across all districts in the country. The Youth Policy also incorporates and prioritises issues facing youth with disabilities and seeks to the development of an enabling environment for the youth with disabilities to realise their full development potential and contribute towards betterment of society.²⁴⁶</p> <p>The National Adolescent Sexual Reproductive Health (ASRH) Strategy (2010-2015) is targeted at the youth aged 10-24 in Zimbabwe and seeks to improve their sexual and reproductive health status through the provision of age appropriate interventions centred on behaviour change communication, life skills and livelihoods, youth-friendly service delivery (YFS), policy and advocacy, and coordination. The strategy also outlines the minimum or essential package for ASRH service provision for the health facility, school or community based approaches.²⁴⁷</p>

²⁴⁵ Government of Zimbabwe, 2014

²⁴⁶ Government of Zimbabwe, 2013

²⁴⁷ Government of Zimbabwe, 2016

5.3 Leadership and governance structures

Leadership and governance structures play an important role in ensuring young persons with disabilities have access to SRHR services. Leadership is a broad concept which can include political will, public will, advocacy and communication. It also spans political, religious, business and civil society spheres and how they collaborate to promote and maintain inclusive access to SRHR services by young persons with disabilities.

Leadership and governance structures are particularly important given that young persons with disabilities and SRHR are both often misunderstood and marginalized and require a strong voice to advocate for the importance and needs of both areas. This section of the report looks at the prioritization of the young persons with disabilities and SRHR agendas and the leadership and governance structures across ESA that impact the ability of young persons with disabilities to access SRHR services. It first considers the role of government, civil society and development partners, and finally structures to ensure representation and participation of youth and young people themselves.

The UNCRPD sets out a number of obligations related to the implementation of the Convention and the requirements for national leadership and governance structures to oversee and monitor its implementation.

First, Article 4 of the Convention obligates states to ensure that persons with disabilities, including children, are consulted and actively involved, through their representative organisations, in the development and implementation of legislation and policies that concern issues affecting them.²⁴⁸

Second, the UNCRPD requires member states to ensure that all facilities and programmes designed to serve people with disabilities are effectively monitored by independent authorities.²⁴⁹ These authorities take various forms, as illustrated in the sections that follow.

Third, the UNCRPD requires that civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring of legislation and policy implementation.²⁵⁰

Finally, the UNCRPD requires that states establish one or more independent mechanisms to promote, protect and monitor implementation of the Convention itself.²⁵¹ The current state of leadership and governance arrangements in ESA countries related to persons with disabilities and the obligations of the UNCRPD are discussed in more detail in this section.

²⁴⁸ UNCRPD, 2006, p6

²⁴⁹ UNCRPD, 2006, p11

²⁵⁰ UNCRPD, 2006, p21

²⁵¹ UNCRPD, 2006, p21

5.3.1 Government

Leadership and governance structures in the ESA member states are responsible for ensuring the realisation and fulfilment of the rights of persons with disabilities as described in the various international, regional and national legislation and policies. Generally within a member state, the organisational structures are such that the responsibility for the general (non-health specific) well-being of persons with disabilities typically falls to one ministry, usually the ministry responsible for social welfare. Other ministries may also include aspects related to persons with disabilities in their mandate.

Table 9: Ministry responsibility for young persons with disabilities

Ministry	Responsibility
Social Welfare/ Social Development/ Community Development	Responsible for the social welfare system in a country to ensure that vulnerable persons such as young persons with disabilities are protected and supported. Nature of social welfare system differs significantly from country to country in ESA region from large social protection and security systems to smaller, basic programmes related to e.g. food security and children's out of home care.
Health	Responsible for ensuring that young persons with disabilities have equal access to healthcare services and ensuring they are able to access appropriate treatment and rehabilitation.
Education	Responsible for ensuring that young persons with disabilities have equal access to education which provides for their needs.
Labour	Responsible for ensuring that young persons with disabilities can access vocational training and employment appropriate to their abilities.
Youth	Responsible for ensuring youth are represented, protected, supported and active in economic, social and other national spheres.

5.3.2 Civil society

Civil society is an important sector to ensure and progress the rights of young persons with disabilities. A number of ESA countries have a coordinating body or 'umbrella' organisation which represents multiple non-governmental organisations (NGOs) focusing on and representing persons with disabilities and young persons with disabilities.

The influence of these umbrella bodies and their constituencies is likely to vary significantly and will depend on several factors within each country. In some cases, organisations may be very active and large groups, in other instances, they may be smaller, or less active. In addition, although these organisations promote the rights of persons with disabilities, their programmes generally focus on advocacy and inclusion of persons with disabilities; it is unclear what their role is in ensuring persons with disabilities have access to SRHR services specifically.

Table 10: Civil society coordinating bodies and 'umbrella' organisations

Country	Coordinating body/organisation
Angola	Federation of Organisations of Disabled People in Angola (FAPED)
Botswana	Botswana Federation of Disabled People (BOFOD) Botswana Council for the Disabled (BCD)
Burundi	Union des Personnes Handicapées du Burundi (Union of the Handicapped of Burundi)
Congo	National Union of Congolese Disabled (UNHACO)
Eritrea	Eritrea does not have a unifying umbrella body for persons with disabilities
Ethiopia	Federation of Ethiopian National Associations of Persons with Disabilities (FENAPD)
Kenya	United Disabled Persons of Kenya (UDPK)
Lesotho	Lesotho National Federation of Organisations of the Disabled (LFNOD)
Madagascar	Platform of the Federations of People with Disabilities (PFPH)
Malawi	Federation of Disability Organisations in Malawi (FEDOMA)
Mauritius	Federation of Disabled Persons Organisation Mauritius
Mozambique	Forum of Associations of Disabled People of Mozambique (FAMOD)
Namibia	National Federation of People with Disabilities in Namibia (NFPDN)
Rwanda	National Union of Disabilities' Organizations of Rwanda (NUDOR)
Seychelles	Seychelles Disabled People Organisation (SDPO)
South Africa	South African Disability Alliance (SADA)
South Sudan	Sudan National Council for Persons with Disabilities
Swaziland	Federation of the Disabled Swaziland (FODSWA)
Tanzania	Tanzania Federation of Disabled Peoples' Organisations (TFDPO) SHIVYAWATA
Uganda	National Union of Disabled Persons of Uganda ((NUDIPU)
Zambia	Zambia Federation of Disability Organisations (ZAFOD) ²⁵²
Zimbabwe	Federation of Organisations of Disabled People in Zimbabwe (FODPZ) ²⁵³

²⁵² Africa Disability Forum

²⁵³ Southern Africa Federation of the Disabled, 2017

Comoros is the only ESA country which does not appear to have a civil society organisation for persons with disabilities.

In addition, there are also a number of regional associations which are responsible for representing persons with disabilities, identifying needs, expressing views on priorities, evaluating services and advocating changes and public awareness on a regional level. Some regional associations include:

- Southern African Federation of Disability (SAFOD)
- The Disability, HIV and AIDS Trust (DHAT)
- The African Campaign on Disability and HIV/AIDS

5.3.3 Multi-sectoral structures

The nature of marginalised or vulnerable groups is such that no one government ministry or civil society group can achieve the objectives of participation and protection typically set out in legal and policy frameworks. Most ESA countries have established multi-sectoral bodies to bring together government, civil society and other sectors to address, monitor and provide direction to various agendas related to marginalised groups.

At least 14 ESA countries appear to have some form of national council for persons with disabilities. The purpose of the council is generally to monitor the multi-sectoral approach to ensuring that the rights of persons with disabilities are upheld. The councils typically focus on all persons with disabilities, not specifically or exclusively young persons with disabilities.

Table 11: National governance structures for young persons with disabilities

Country	Structure	Description
Angola	National Council for People with Disabilities (NCPD)	The mandate of the Council is unclear as there is no updated literature available.
Botswana		Not identified in desktop research
Kenya	National Council for Persons with Disabilities (NCPWD)	The Council is a state corporation established by an Act of Parliament the Persons with Disabilities Act No. 14 of 2003. The Council is drawn from key government Ministries and organisations of/for persons with disabilities. Key activities of the organisation include advocating for rights of persons with disabilities and advocating for equal representation of persons with disabilities at all levels of decision making. ²⁵⁴
Malawi	The Malawi Council for the	The Council was established by an Act of Parliament the Handicapped Persons Act 1971 Cap: 33:02 as a statutory corporation. The mission of the Council is to implement government policies by providing rehabilitation programs and

²⁵⁴ NCPWD, 2017

Country	Structure	Description
	Handicapped (MACOHA)	services and promoting public interest for the empowerment of persons with disabilities in order to achieve an inclusive society. Activities of the Council include implementing HIV and AIDS Impact Mitigation which aims to increase access to HIV and AIDS prevention and care services by persons with disabilities. ²⁵⁵
Mauritius	National Council for the Rehabilitation of Disabled Persons (NCRD)	The National Council for the Rehabilitation of Disabled Persons was set up by an act of Parliament in 1986. The objectives of the Council are to coordinate the activities of voluntary organisations catering for disabled persons, to promote the development and expansion of rehabilitation services and to generally promote the welfare of disabled persons. The Council has no direct mandate regarding SRH of persons with disabilities. ²⁵⁶
Mozambique	National Council for Disabilities	A report by the Disability and Development Partners in Mozambique ²⁵⁷ found that the country had made plans to establish a National Disability Council however this has not materialised for lack of financial means. It is unclear in recent years whether the Council has been established and active.
Namibia	National Disability Council	The Council was established as a result of the passing of the National Disability Council Act, 2004 by Parliament. The Council is established to promote the equal rights of persons with disabilities and to monitor the implementation of the National Policy of Disability. ²⁵⁸
Rwanda	National Council for Persons with Disabilities (NCPD)	The National Council of Persons with Disabilities was created by the Constitution of June 2003 and this act of government established its responsibilities, organisation and functioning. The Council assists Government to implement programs and policies that benefit persons with disabilities. The Council has no clear mandate relating to SRHR of persons with disabilities.
Seychelles	National Council for the Disabled (NCFD)	The Council was established by the Disabled Persons Act, 1994. The Council intends to coordinate activities of public and private organisations engaged in the welfare of persons with disabilities. The Council works with civil and private organisations to promote, provide assistance, develop and organise services for rehabilitation and secure employment for persons with disabilities. The Council has no mandate towards the promotion of SRHR of persons with disabilities.

²⁵⁵ MACOHA

²⁵⁶ National Policy paper and Action Plan on Disability, 2007

²⁵⁷ Disability And Hiv & Aids In Mozambique, 2008

²⁵⁸ National Disability Council, 2017

Country	Structure	Description
South Africa	National Council for Persons with Physical Disabilities in South Africa (NCPDPSA)	The Council is a non-governmental non-profit organisation that has a vision to empower every person with a disability to ensure that persons with disabilities attain their full rights as citizens. The Council achieves this through advocacy programmes, changing attitudes through sensitisation and awareness programmes and contributing to and influencing government policies.
South Sudan	National Council for Persons with Disabilities	The Disability Act provides for the setting up of a National Council for persons with disabilities to oversee and coordinate the implementation of the Act. ²⁵⁹ It is unclear whether this Council has been established and their activities are not provided in the literature.
Swaziland	National Committee of Persons with Disabilities	The Persons with Disabilities Bill, 2004 proposes the establishment of a National Committee of Persons with Disabilities. The objectives of the Committee are to ensure that all persons with disabilities have equal access and opportunities to education, health and other services at all levels and to improve the socio-economic status of persons with disabilities. ²⁶⁰
Zambia	Zambia Agency for Persons with Disabilities	The Ministry of Legal Affairs was tasked with the establishment of a government agency for persons with disabilities. The Agency has the responsibility to coordinate the implementation of the National Policy on Disability and acts as an advisory body to the Ministry. ²⁶¹
Zimbabwe	National Disability Board	The Disabled Persons Act (Chapter 17:01) establishes the National Disability Board and sets out the functions of this body. ²⁶² The Board is responsible for the policies that concern persons with disabilities in the country and reports to the Minister.

Information on national multi-sectoral governance bodies for persons with disabilities was not publicly available or found through desktop research for the following nine countries:

- Burundi
- Comoros
- Congo
- Eritrea
- Ethiopia

²⁵⁹ Sida Disability Rights in Sudan and South Sudan, 2014

²⁶⁰ University of Pretoria, 2014

²⁶¹ National Assembly of Zambia, 2017

²⁶² University of Pretoria, 2014

- Lesotho
- Madagascar
- Tanzania
- Uganda

5.3.4 Youth representation and participation

An important factor in whether the rights of young persons with disabilities are sufficiently represented in the national agenda is the extent to which young people themselves are included and actively participate in issues that concern them.

There has been an increasing focus on young people across the ESA region in recent years, due to both the potential demographic dividend and the costs to society when youth are disenfranchised. In some countries, youth are encouraged to participate in policy-making, youth structures and processes. The EAC indicates in their strategic plan that while these initiatives are encouraged, they are often poorly resourced and young people often lack the capacity or know-how to engage effectively.²⁶³

The strategic plan has developed a logical framework for youth empowerment with critical success factors. One of the assumptions in this framework is the political will of EAC member states and a commitment to youth participation. The success and prioritisation of youth empowerment and participation initiatives is thus dependent on the country's leadership and political will.

The UN is a strong advocate for youth participation and has supported a number of initiatives in the region to help ensure youth are more involved in the decision-making that affects their lives. The UN has recognised that through active participation, youth are empowered to play a vital role in their social and economic development. Participation can be strengthened by including youth in the design and implementation of strategies and programmes. Youth participation can also be improved through education and capacity building.²⁶⁴

Some of the youth participation initiatives in the ESA region include²⁶⁵:

- Africa Youth Parliament (AYP) - the AYP is a continent-wide network of young leaders, advocating for youthful solutions to Africa's development challenges. The AYP formulates individual and collective action plans to address issues from a continental perspective such as HIV/AIDS, democracy and governance.²⁶⁶ The network does not specifically address issues related to SRHR.
- South African Youth Forum - the purpose of this forum is to provide a platform for youth in SADC to develop recommendations on key youth issues. One of the key priorities of the forum is strengthening health service delivery, including SRH, to

²⁶³ EAC, 2012

²⁶⁴ United Nations Youth, 2017

²⁶⁵ United Nations, 2017

²⁶⁶ African Youth Parliament, 2011

prevent problems such as child marriages, teenage pregnancies, and sexual abuse and to ensure youth well-being.²⁶⁷

- African Youth and Adolescent Network on Population and Development (AfriYan) - the AfriYan is a consultative, coordinated and action oriented network for youth and adolescent national organisations. The organisation focusses on health and advocacy such as the promotion of SRHR and population and youth development.²⁶⁸
- South African Youth Movement - the Youth Movement seeks to ensure that the talents of young people are used in national and regional economic development initiatives. The organisation focuses on programs such as integrated drug and substance abuse and promoting civil participation. The organisation does not appear to have an explicit focus on SRHR.²⁶⁹

Specifically, young persons with disabilities are represented by the African Youth with Disabilities Network (AYWDN), which has its headquarters in Nairobi, Kenya. AYWDN chapters represent the network at a country level. AYWDN has a specific programme focused on access to sexuality education and SHHR services for young persons with disabilities. The programme goal is to ensure young persons with disabilities are receiving sexual education and have equal access to affordable and reliable health services.²⁷⁰

The programme aims to provide knowledge and understanding, ensure that supportive and caring environments are conducive to the development of each person and that every person is in charge of and responsible for their own sexual health. The programme aims to address the barriers that typically prevent young persons with disabilities from accessing quality sexual education and health services and achieves this by partnering with stakeholders such as health educators and medical service providers.

Currently, AYWDN chapters exist in eight of the ESA countries

- Ethiopia
- Kenya
- Namibia
- Rwanda
- South Sudan
- Uganda
- Zambia and
- Zimbabwe

15 ESA countries do not currently have a national AYWDN chapter.

²⁶⁷ SADC, 2014

²⁶⁸ African Youth and Adolescent Network on Population and Development, 2017

²⁶⁹ Southern Africa Youth Movement, 2014

²⁷⁰ AYWDN, 2013

5.4 Funding

While the UNCRPD does not specifically state what should and shouldn't be funded by member states, it makes very clear what should be provided for persons with disabilities and, as such, it can be logically concluded that funding is necessary to achieve these obligations. The only specific mention of cost in the Convention is in Article 20 which obligates member states to facilitate access for persons with disabilities to assistive devices and technologies by making them available at an affordable cost.²⁷¹

The UNCRPD, recognising the varying economic positions of member states, speaks to the progressive realisation of these obligations, acknowledging that immediate realisation is often not feasible given the costs associated with many of the obligations.

In order to achieve their intended objectives, regional and national strategies related to increasing access to SRHR by young persons with disabilities must be costed and funded. Determining the amount or source of current funding for SRHR services or programmes for young persons with disabilities is very difficult.

There are a limited number of initiatives which address SRHR for young persons with disabilities specifically. Data on this level of intervention is frequently not publicly available or even tracked within an organisation, such as a ministry, at that level. There are broader SRHR services or programmes which young persons with disabilities may benefit from without any direct targeting. However, given the limitations of data on young persons with disabilities who access such services or programmes, it is extremely difficult to understand the portion of funding that supports young persons with disabilities. There is also a risk that without specific targeting, young persons with disabilities would not actually benefit from general population programmes for SRHR.

Notwithstanding these challenges, this section intends to highlight some of the key sources of funding for SRHR and/or Y/persons with disabilities across ESA to provide a starting point for understanding the total "pot" of funds for SRHR for young persons with disabilities in the region.

5.4.1 Government funding

Government funding for ensuring access to SRHR services by young persons with disabilities is typically part of social welfare, healthcare and education budget provisions. However, budgets typically follow programmatic structures so similar to how there are limited programmes which specifically consider the needs of young persons with disabilities with respect to SRHR services, budgets are also not necessarily broken down. Specific line items which are allocated to persons with disabilities, not necessarily related to SRHR, and not specific to young persons with disabilities include:

- Disability grants

²⁷¹ UNCRPD, 2006, p12

- Products and technology for persons with disabilities
- Special schools for children and YPWDs

In recent years, government funding for HIV in ESA has increased considerably. However many countries remain reliant on donor funding from international or private funders which can have repercussions for the sustainability of their HIV response. South Africa and Botswana have been exceptions within the region. The majority of HIV spend in these two countries comes from public funding. The government of Botswana provides approximately 70% towards the total HIV spend. Zimbabwe has also gained instrumental support through its innovative approach of a 3% AIDS levy on all taxable income.

HIV services and products are part of the broader SRHR agenda. As the nature of the HIV epidemic changes in the region. There may be potential to redirect funding towards support for SRHR services, not just specifically HIV services and commodities.

5.4.2 Development partner funding

Health, education and social development sectors in most ESA countries receive additional support, either directly or indirectly, from donor agencies. Across the ESA region, donor support varies significantly depending on criteria such as national income status and whether the country is experiencing conflict. Many of the donors in the region are multi- or bi-lateral organisations, whereby the funding for their development work comes from one or more governments from the Western/developed world.

Donor funding for SRHR tends to be easier to estimate as the programmatic structure of development partner activities in the region is often focused on SRHR and HIV/AIDS in many instances. However, funding specifically for young persons with disabilities within these interventions is not specified.

In addition to donor funding, many international NGOs, such as Handicap International and Planned Parenthood, have large SRHR and/or young persons with disabilities programmes in the region.

5.4.3 High level budget estimate

Notwithstanding the challenges in identifying and specifying funding for access to SRHR by young persons with disabilities, the table below attempts to provide a high level, directional sense of funding that is available for either SRHR, young persons with disabilities or persons with disabilities in the region. As government data is not publically accessible in a meaningful way, the table focuses on development partner budgets. Actual data for SRHR spend was often not specified but the total budget and purpose is indicted to give a sense of what might be budgeted for SRHR.

Both funders and implementers are included in the table as some organisations play both roles. The international NGOs included in the table may receive funding from the donors listed, so caution should be applied to interpreting the numbers below which may 'double-count' the actual funding in the region for SRHR and/or young persons with disabilities.

Table 12: Development partner budgets

Development partner	Budget	Notes
DFID (UK AID)	£ 2,323,080,320 Total DFID Official Development Assistance to Africa of which 58% was geared towards the ESA region in 2014. ²⁷²	Data for 2016. Not specified towards SRHR for young persons with disabilities however focus areas include: Health, education, vulnerability, sanitation, and security relevant to this topic. ²⁷³
Dutch Ministry of Foreign Affairs	€4.34 billion was spent on development cooperation in 2012 which constituted 0.7% of GDP. ²⁷⁴	Official Development Assistance (ODA) constituted 0.7% of GDP in 2014 as well with the following four focus areas (a) security and the legal order, (b) food security, (c) water and (d) Sexual and Reproductive Health and Rights (SRHR). In addition the Dutch Ministry of Foreign affairs ODA focused on the 15 countries, 6 of which are in the ESA region, namely Ethiopia, Mozambique, Uganda, Rwanda, Burundi, and Kenya. ²⁷⁵
EuropeAid (European Union)	Over EUR 10.3 billion in official development assistance (ODA) in 2015 by the European Commission. ²⁷⁶	Data for 2015. This includes numerous initiatives across Africa. ²⁷⁷
The Global Fund to fight AIDS, Tuberculosis and Malaria	USD 3,359,000,000 in 2016 towards HIV- AIDS, Tuberculosis and Malaria. ²⁷⁸	Data for 2016. ²⁷⁹
Handicap International	EUR 123,000,000 total in 2015 Programmes Specific Expenditure by Handicap International of which Africa and the Indian Ocean EUR 39,700,000 which equated to 32.3 % of total expenditure. ²⁸⁰	Data for 2015. ²⁸¹

²⁷² Government of the United Kingdom, 2016

²⁷³ Government of the United Kingdom, 2016

²⁷⁴ Government of the Netherlands, 2011a

²⁷⁵ Government of the Netherlands, 2011b

²⁷⁶ European Commission, 2016

²⁷⁷ European Commission, 2016

²⁷⁸ The Global Fund, 2016

²⁷⁹ The Global Fund, 2016

²⁸⁰ Handicap International, 2015

²⁸¹ Handicap International, 2015

Development partner	Budget	Notes
International Planned Parenthood Federation	IPPF spent a total of USD 131,800,000 in 2015, of this, 36% of which was spent on access, 10% on advocacy, 17% on abortion, 12% on adolescents, and 4% on HIV programmes. ²⁸²	Data for 2015. ²⁸³
Save the Children	Combined Revenues for 2015 was USD 2,100,000,000. Of this 20% was spent on East Africa, 6% on Southern Africa, and 15% on West and Central Africa with focus areas of health and nutrition, education, child protection, child poverty/livelihoods, and Child rights governance. ²⁸⁴	Data for 2015. ²⁸⁵
Swedish International Development Cooperation (Sida)	Sida manages SEK 33.5 billion of the funds allocated towards development cooperation to create better living conditions for people living in poverty and oppression. ²⁸⁶	Data for 2017. Total and not specified towards SRHR for young persons with disabilities however Sida's 8 thematic areas included the following: Defended human security and freedom from violence, Democracy, respect for human rights and freedom from oppression, Inclusive and sustainable economic development, including employment and decent work conditions, Health, and Education and research.
UNFPA	USD 181,817,709 ²⁸⁷	Data for 2017. This is the total budget for ESA of which of which 68.1% is dedicated towards Integrated SRHR Services and 14.1% is dedicated to Adolescents and Youth. ²⁸⁸
USAID	USD 2,208,508 was spent on programmes within Africa as a programme area, this accounted for 17.68% of the total programme expenditure in all USAIDs programme areas in 2016. ²⁸⁹	Data for 2016
UNAIDS	USD 484,820,000 core resources funding of which 26% is allocated towards high impact countries. ²⁹⁰	

²⁸² International Planned Parenthood Association, 2016

²⁸³ International Planned Parenthood Association, 2016

²⁸⁴ Save the Children International, 2016

²⁸⁵ Save the Children International, 2016.

²⁸⁶ Sida, 2017.

²⁸⁷ UNFPA, 2017c

²⁸⁸ UNFPA, 2017c

²⁸⁹ USAID, 2017

²⁹⁰ UNAIDS, 2013

Development partner	Budget	Notes
	The Majority of which are in the ESA region. ²⁹¹	
UNDP	The total contributions by UNDP in 2015 was USD 4,486,000,000. ²⁹²	Data for 2015. This is the total contributions received. Notably, South Sudan and Democratic Republic of Congo were in the top 10 pooled funds recipients with USD 41 million and 26 Million respectively. ²⁹³ In addition UNDP contributes to the UN Partnership to Promote Rights of persons with disabilities (UNPRPD) and in 2015 it contributed a total of USD 1,885,473. ²⁹⁴
UNESCO	Africa had a regional allocation of 21.6% of the USD 126,611,800 of UNESCO's budget for the period 2014 -2017. ²⁹⁵	Data published in 2014. This is the total budget of for 2014 -2017 of its Regular Programmes excluding UNESCO Educational Institute Costs. This includes Major Programmes of Education and Social and Human Sciences as well as the programme related service of coordination and monitoring of action to benefit Africa. ²⁹⁶
UNICEF	USD 5,009,000,000 is UNICEF's total revenue in 2015. ²⁹⁷	Data for 2015. This is the total revenue for UNFPA of which specific allocation for young persons with disabilities in terms of SRHR is unknown. Young persons with disabilities are specifically mentioned in programme priorities of social inclusion and education. ²⁹⁸ UNICEF also focuses on the ESA region having a specific regional office allocation. ²⁹⁹
World Bank	Of the USD 35,723,000,000 Disbursements from the World Bank 21% went to Africa. ³⁰⁰	Data for fiscal year 2016.

²⁹¹ UNAIDS, 2014

²⁹² UNDP, 2016

²⁹³ UNDP, 2016

²⁹⁴ UNPRPD, 2017

²⁹⁵ UNESCO, 2014

²⁹⁶ UNESCO, 2014

²⁹⁷ UNICEF, 2016

²⁹⁸ UNICEF, 2016

²⁹⁹ UNICEF, 2017

³⁰⁰ World Bank, 2017

5.5 Workforce

Workforce refers to the service providers, professionals, employees and volunteers responsible for providing SRHR information and services or ensuring that young persons with disabilities can access services and exercise their rights. SRHR service providers include healthcare providers, community caregivers, social workers, CSE teachers, police, courts and traditional healers among others. The workforce plays an essential role in ensuring access to good quality SRHR.

The UNCRPD sets out a number of obligations for member states related to the training and conduct of those who work with and provide services to persons with disabilities. The Convention requires member states to ensure such professionals and staff are sufficiently trained on the rights of persons with disabilities recognised in the Convention in order that they can provide the assistance and services guaranteed by those rights.³⁰¹

The Convention also notes that those who work with persons with disabilities come from a range of sectors, including health, justice, and education.³⁰² The education workforce should be trained in the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.³⁰³ Health workers must provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent.³⁰⁴

This section considers the availability, skills, expertise, experience and training of the workforce to provide SRHR services to young persons with disabilities. It also looks at the policy considerations for youth-friendly services (YFS) in ESA countries.

5.5.1 Intersectionality of age, disability, gender and SRHR

The issues related to workforce described in this sector are all exacerbated by the intersection of age, disability, gender and issues of SRHR. Both SRHR and disabilities are commonly misunderstood across the ESA region and health care providers are no exception to the cultural attitudes and perceptions that impact the ability of young persons with disabilities to access services, particularly SRHR.

The issues identified below, such as lack of training and availability of service providers who understand SRHR services or young persons with disabilities, are more acutely felt when young persons with disabilities try to access SRHR services. For example, even where SRHR service providers are sufficiently trained on SRHR issues, they may not have adequate training on how SRHR needs and services relate to young persons with

³⁰¹ UNCRPD, 2006, p5

³⁰² UNCRPD, 2006, p10

³⁰³ UNCRPD, 2006, p15

³⁰⁴ UNCRPD, 2006, p16

disabilities, and vice versa. Young persons with disabilities are therefore most impacted by SRHR workforce challenges in the region.

5.5.2 Availability

Adequate availability of professionals and trained workers is a critical success factor in the provision of SRHR services to young persons with disabilities, across healthcare, education and justice systems as well as others such as social welfare (social workers), community development and youth. The presence of skilled workers is an essential component of any functioning SRHR system.

There is a scarcity of healthcare workers in the ESA region. According to the Global Health Workforce Alliance reports published by the WHO, Africa is in need of 1.5 million healthcare professionals including doctors, nurses, midwives and community healthcare workers.³⁰⁵ This shortage can be attributed in part to lack of adequate education and training of healthcare workers.

In addition, the healthcare systems in Africa are significantly impacted by the brain drain of health professionals from the continent.³⁰⁶ According to the WHO, many qualified and trained healthcare professionals from Africa choose to migrate to developed countries in search of better opportunities and working conditions.³⁰⁷ This results in a scarcity of workers in the countries where they are needed the most.

The limited availability of healthcare workers in Africa is further challenged by heavy workload, inadequate infrastructure and shortages in medical supplies. This places immense pressure on healthcare workers to perform their duties effectively within the constraints of limited resources.³⁰⁸ This can have significant effects on the quality of healthcare provided. For example, when healthcare providers are overworked, they may be rushed, irritated or otherwise disengaged with their work. This impacts their ability to provide sufficient levels of patient care and attention. This can discourage young people in particular from utilising services.

Similar challenges are noted in the availability of professional teaching staff and educators, particularly in the roll out of comprehensive sexuality education in schools.³⁰⁹ Data on justice workforce was not available.

³⁰⁵ Novartis, 2013

³⁰⁶ Naicker et al., 2009

³⁰⁷ Kissick, undated

³⁰⁸ Masebeo and Maharajb, 2017

³⁰⁹ UNESCO, 2016

5.5.3 Training

Lack of skills among staff can hinder SRHR service providers to provide appropriate and quality services.

The SRHR needs of young persons with disabilities are more often disregarded by service providers due to lack of knowledge of needs, rights, the specifics of the disability and service requirements. The SRHR workforce is often ill-equipped to provide appropriate SRHR services as their training may have focused on SRHR but not disability. The lack of understanding of the disability itself can restrict the effectiveness of the SRHR service. For example, SRHR service providers may not have the training or capacity to communicate with service users with disabilities, such as deaf service users. This means they cannot provide appropriate information or advice, or correctly diagnose or respond to issues of SRHR.

5.5.4 Attitudes and cultural beliefs

Access to quality SRHR services can be compromised by negative attitudes and harmful cultural beliefs among service providers. Speaking openly about sex and reproductive health, particularly with young people, is frequently considered taboo.³¹⁰ Even among SRHR service providers, professionals can disregard or can even disapprove of the SRHR needs of young people and particularly young persons with disabilities based on perceptions they hold on a personal level.

Across ESA countries, there are reports of insensitive healthcare workers who are dismissive of persons with disabilities and young persons with disabilities.³¹¹ Young persons with disabilities are more susceptible to the prejudices of SRHR service providers, limiting their access to SRHR information and services. In some cases healthcare providers are not prepared to provide young people and persons with disabilities some SRHR services because they don't think that these people should be having sex.

Similar issues can be observed across other services providers, such as teachers responsible for providing CSE in schools. Personal biases of educators can have a major influence on the depth and quality sexual and reproductive information dissemination to young people. Therefore YPDW lack the necessary SRHR information to address their needs and inform their choices.

5.5.5 Policy considerations

The need to ensure healthcare services, including SRHR services, are youth friendly has been broadly recognized across the ESA region, and is part of the ESA Commitment. Some countries have integrated the need for YFS into their policies, and developed minimum standards for YFS. However, implementation of this intent remains a significant challenge. It

³¹⁰ UNESCO, 2016

³¹¹ WHO, 2011

requires large scale training in order that all healthcare workers across the region are sensitised and trained to provide youth friendly services, and that the provision of such services are monitored. There was very little evidence across the ESA region of extensive sensitisation training, or monitoring, of healthcare workers in order to provide YFS.³¹²

³¹² UNESCO, 2016

5.6 Knowledge management

Knowledge management is an essential component of any effective strategy for social change in order to understand the context of the situation, to direct and refine initiatives to enhance their effectiveness and efficiency and to ensure lessons are learned and programme and service delivery is based on evidence of what works.

Strengthening the knowledge management of SRHR for young persons with disabilities has the potential to contribute towards more effective planning, more appropriate policy making in ESA countries and ultimately improved outcomes for young persons with disabilities.

The UNCRPD obligates member states to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the Convention, and the rights of persons with disabilities. The information is required to be disaggregated, as appropriate, and used to help assess progress in implementing the Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.³¹³

This section considers the extent to which information and data on SRHR for YPMD is collected and how it is used, both within ESA countries and across the region.

5.6.1 SRHR and young persons with disabilities research

Across the region, information and research regarding SRHR for persons with disabilities, and in particular young persons with disabilities, is severely lacking. Overall there is limited research on disabilities and young persons with disabilities, which in turn means even less research on SRHR for young persons with disabilities.

The burden of the HIV epidemic experienced by ESA countries could have provided a platform for intensive research on HIV and SRHR issues. The ESA region is home to ten of the countries with the highest prevalence of HIV in the world in addition to having the highest number of young people in the world.³¹⁴ Data collection to inform research, contribute to the national evidence base and policy development on SRHR issues has become increasingly available across the region. However, overall, there remains insufficient research particularly on the intersection of disability, HIV and/or SRHR.

Following the growing recognition of the needs and rights of persons with disabilities both internationally and within the region, more effort has been placed on establishing an evidence base on disabilities. Like the need for SRHR information, data on persons with disabilities and young persons with disabilities is critical to informing policy and directing strategies. However, to date, information on disabilities, and specifically young persons with disabilities, has been considered a gap among many countries in the region.

³¹³ UNCRPD, 2006, p20

³¹⁴ MacPherson, 2014

The Pretoria University Law Press (PULP) from the Faculty of Law at the University of Pretoria has been instrumental documenting the situation of persons with disabilities in African countries in their African Disability Rights Yearbook (ADRY).³¹⁵ The ADRY is a peer-reviewed journal that is published once a year with 2013 as its augural year and provides a peer review of prior publications.

Considering that many ESA countries lack the required capacity to undertake research, research conducted by international agencies are a critical contributor to the body of information available to the region. Some of these agencies include the WHO, World Bank, and UN agencies, particularly UNAIDS, UNESCO, UNFPA and UNICEF.

In addition to these agencies, many countries receive both technical and financial support to conduct research from other countries governments or funding agencies. One such example is that of the Netherlands Organisation for Scientific Research (NWO), Science for Global Development which awarded funding in 2015 for an SRHR research project to be carried out in the Great Lakes region. This research includes a study to better understand social and cultural barriers and facilitators on reaching out-of-school young persons with disabilities and how to include them in SRHR programmes.³¹⁶

Save the Children has conducted a research study into the key issues affecting children in Africa, within the context of sexuality and HIV. Some of the findings which are particularly relevant to young persons with disabilities relate to the lack of data surrounding children with disabilities. The findings were:

- Existing data and research lacks the voices of children living with disabilities. There is very little knowledge of these children's needs, knowledge, and information requirements.
- There is very little data which provides insight into the situation of children with disabilities i.e. prevalence of disabilities amongst children, attendance at school by children with disabilities etc.³¹⁷

5.6.2 Census data

On a national level, most ESA countries perform a national census. Some countries perform these every four years, while others perform them every ten years. Most countries include SRHR related questions in their census. These indicators have been of particular relevance for the ESA countries as they address the impact of the HIV epidemic in their countries.

³¹⁵ University of Pretoria. 2014

³¹⁶ NWO, 2015

³¹⁷ Save The Children International, 2016

While most national censuses have included indicators for disabilities, the definition and/or indicators are often unsuitable for analytical purposes. Countries such as Kenya, South Africa, Swaziland and Namibia have, through the inclusion of disability questions in their survey, been able to produce disability reports for their country.

Table 13: Disability-specific reports generated from census data

Country	Disability data
Kenya	2009 Population and Housing Census: Analytical Report on Disability (published 2012)
South Africa	Census 2011: Profile of Persons with Disabilities in South Africa South African Department of Social Development: Elements of the financial and economic costs of disability to households in South Africa. Results from a pilot study, DSD, UNICEF: Johannesburg (2016)
Swaziland	Swaziland Population and Housing Census 2007: Fertility, Nuptiality, Disability and Mortality
Namibia	Namibia 2011 Census Disability Report.

5.6.3 Demographic Health and other surveys

In addition to a national census, many ESA countries undertake Demographic and Health Surveys (DHS) every five years. The DHS provides nationally-representative and regular data on demographic, health, nutrition and SRHR trends. However, these surveys do not collect any data on the disability status of the respondents.

Some countries also use the General Household Survey and other surveys. Again, the disability indicators used can vary. Countries in Southern Africa have also initiated a Living Conditions among Persons with Disability Survey. These surveys have also contributed significantly to the body of information available regarding disabilities in the region.

5.6.4 Data collection and reporting

A common challenge related to data and information in the region is that national statistics bureaus and other national research facilities face significant capacity constraints. There are insufficient numbers of skilled human resources, a lack of sufficient financial resources and a lack of coordination of health-related research in most countries in the region. This can delay reporting and analysis on census and other data, often resulting in information being outdated.³¹⁸

In general, while information and research for SRHR has been more extensive and appears to be ongoing; there remains very limited information on persons with disabilities and young

³¹⁸ UNESCO, 2016

persons with disabilities in particular. Adding a small number of disability-related questions to existing surveys would contribute significantly to the body of information. It would allow analysis of the situation of young persons with disabilities, in terms of age, race, living conditions, health status, and access to services.

5.7 Products, technology and commodities

This section is two pronged and considers the assistive devices and technologies and the SRHR products and commodities that impact on the access of young persons with disabilities to SRHR.

This section should be read in parallel with the services and programmes section which are the mechanisms through which products, commodities and technologies are distributed or utilized.

5.7.1 Assistive devices and technologies

According to the WHO, assistive devices and technologies refers to “any piece of equipment, or product, whether it is acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities”.³¹⁹ These devices and technologies help persons with disabilities achieve personal mobility and self-sufficiency. Assistive devices also play a significant role in improving the quality and dignity of life for persons with disabilities.³²⁰

Examples of assistive devices and technologies include wheelchair, speech communication devices, home modification and portable ramps, voice-to-text- systems, visual alert systems, hearing aids and listening devices, lifts and vehicle modifications, and braille printers.³²¹

Appropriate assistive devices and technologies can benefit young persons with disabilities by rectifying, compensating for or alleviating the limitations they experience and help young persons with disabilities to be independent and empowered.³²² For instance, assistive devices have been found to improve mobility and create community participation especially in education and employment.³²³ Similarly, assistive technologies can contribute to improving access of young persons with disabilities to SRHR information and services.

The UNCRPD obligates member states to promote and ensure the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, at an affordable cost.³²⁴ A key principle of the Convention is that of “universal design”. “Universal design” means the design of products, environments, programmes and services to be usable by all people, to the extent possible, without the need for adaptation or specialized design.³²⁵

³¹⁹ WHO, 2011

³²⁰ UN, 1993

³²¹ Losinio, 2016

³²² National Dissemination Center for Children with Disabilities, 2012

³²³ National Institute of Health, no date.

³²⁴ UNCRPD, 2006, p5

³²⁵ UNCRPD, 2006, p4

Assistive devices and technologies help ensure young persons with disabilities can access SRHR services in a number of ways. For example, speech communication devices and hearing aids enable young people with speech or hearing impairments to communicate with healthcare providers. This allows young persons with disabilities to access SRHR information and services independently of a caregiver and with dignity. Similarly, wheelchairs or other mobility devices can enable a young person with a physical disability to access an SRHR service centre. (It is important to note that SRHR service providers must also ensure that young persons with disabilities can access their facilities, ensuring wheelchair access via ramps, for example)

While government in ESA countries is typically responsible for providing certain basic healthcare and/or funding for such healthcare, it is difficult to identify data on the provision of or spending on assistive devices and technologies for persons with disabilities or young persons with disabilities. Demand for such support often exceeds supply or funding for supply, therefore impacting the ability of young persons with disabilities to access SRHR services. In a number of countries, disability councils and bodies aid in the provision of assistive devices and technologies. International agencies such as Handicap International have featured prominently across many countries as a partner in the provision of assistive devices and technologies.

5.7.2 Sexual and reproductive health products and commodities

Access to SRHR products and commodities is instrumental to promoting good SRHR. However young people often have limited access to quality SRHR product and commodities.³²⁶ More so, young persons with disabilities who are more vulnerable to social, economic and civic discrimination, as described previously.³²⁷ This often means that young persons with disabilities experience additional limitations when it comes to accessing sexual and reproductive health products and commodities.

SRHR products and commodities include HIV testing kits, contraception including condoms, elimination of mother-to-child transmission of HIV (eMTCT) through early testing, PEP and PreP, amongst others. Progress in the provision of SRHR products and technologies varies across countries and is dependent on the products and technologies themselves.

The concept of universal design, set out in the UNCPRD, is particularly relevant to SRHR products and commodities. The desired state is for such products and commodities to be universally designed, to increase accessibility by persons with disabilities and reduce the stigma associated with modified designs.

³²⁶ Kassa et al., 2016.

³²⁷ Kassa et al., 2016.

5.7.2.1 Condoms and contraception

The consistent use of protective measures such as male and female condoms have been noted as the most effective way to reduce the sexual transmission of HIV. However, regular use of condoms is dependent on the appropriate supply and demand. Surveys conducted in clinics in countries such as Kenya, Namibia, Rwanda, Tanzania and Uganda between 2006 and 2010 showed that the provision of condoms was inconsistent: almost one in five health care facilities offering family planning services did not typically stock condoms.³²⁸ However, other research in the Kilifi district in Kenya has revealed that the use of condoms is low even when condoms are freely available.³²⁹ Ensuring sufficient availability of condoms is therefore no guarantee of their usage.

Currently, the use of female condoms is considered the only female-initiated HIV prevention tool that functions as both a contraceptive and a means to reduce the risk of transmitting and acquiring sexually transmitted infections.³³⁰ Although female condoms have been introduced in many countries, supply and uptake in countries is low in the majority of countries in the region.³³¹ This may be because female condoms are more expensive than male condoms, and are poorly marketed or understood.

General contraceptive use among young people is extremely low, particularly among the poorest youth, with less than 5% of poorest young people using modern contraception.³³² Adolescents experience many challenges with obtaining contraceptives especially in terms of availability, accessibility and acceptability.³³³ Although services and supplies are available to the general public, young people have restricted access due to legislation or of the personal value judgements of service providers.³³⁴ These challenges resonate more strongly with young persons with disabilities, as they are often perceived as not being sexually active and therefore do not require SRHR products and commodities. Even if young persons with disabilities are able to access contraception, and condoms in particular, young persons with disabilities and particularly young women with disabilities that are sexually active often lack the negotiating power when it comes to condom use by or with a partner.

Other services, such as family planning, including contraception can be challenging to access. Many of the ESA countries, in particular the more conservative East African countries, are very religious and still adhere strongly to cultural norms. The use of contraception is in some cases in contradiction to the rules or norms of the religions or cultures. In addition to this, churches are frequently the providers of healthcare services in some of the ESA countries. As an example, a number of clinics and hospitals in Lesotho are

³²⁸ Atun et al., 2011.

³²⁹ Papo et al., 2011.

³³⁰ UNAIDS, 2013

³³¹ UNAIDS, 2013

³³² UNFPA, 2012

³³³ WHO, 2011

³³⁴ UNESCO, 2013

run by the Roman Catholic Church. These facilities do not offer 'artificial' family planning products or services.

5.7.2.2 Drug stock outs

A number of ESA countries have been rolling out large ARV programmes. These programmes have put some strain on the health systems of the country. In some instances this results in drug stock outs.³³⁵ One of the major implications of ARV stock outs is the detrimental impact on the progression of the disease. Some of the reasons cited for these stock outs in Tanzania included inefficient supply systems, quantification problems and short expiry duration.³³⁶ As a means to prevent non-adherence to the ARV regime or a changing of the regime, healthcare workers may attempt to access medication from another facility, borrowing from other patients or shortening the refill time. In some cases, patients will purchase the necessary medications from a private supplier.³³⁷ All of these cause costly inconveniences for the patient.

In addition to stock out, there are also challenges associated with the amount or type of drugs stocked by certain facilities. One study found that in healthcare facilities in Kenya, Ghana and Uganda, the more complex the range of services the facility provided the wider range of pharmaceuticals they would have available.³³⁸ This means that smaller facilities, located in rural areas usually have a very limited range of pharmaceutical stock.

Stock outs of reproductive health commodities are also a challenge. The UNFPA programme to procure reproductive health commodities, discussed in more detail in the services and programmes section, also experiences similar challenges of inefficient supply systems which cause commodities to not reach their intended recipients and limits the impact of government and donor funding on reproductive health.

³³⁵ Mori and Ownya, 2014

³³⁶ Mori and Ownya, 2014

³³⁷ Masters, 2013

³³⁸ Masters, 2013

5.8 Service delivery and programmes

This section of the situational analysis looks specifically at the key SRHR services and programmes for young persons with disabilities. It considers the aspects of the design of such services and programmes that are important to ensure necessary results and impact are achieved, such as physical accessibility, social, religious and cultural barriers and challenges, social and behavioural change methods and the inclusion of young persons with disabilities in programme and service planning.

The UNCRPD sets out a number of obligations for member states related to the design and provision of services and programmes for persons with disabilities. The principle of “universal design” is also relevant to programmes and services, necessitating that these be usable by all people, to the extent possible, without the need for adaptation or specialized design.³³⁹ These obligations are included in the relevant sections below.

There are a number of lessons learned in planning SRHR services and programmes for young persons with disabilities based on previous efforts. These are important considerations for future strategies to ensure access for young persons with disabilities. Generally speaking, the availability and access to SRHR and other services are not geared towards the needs of persons with disabilities.³⁴⁰

This section discusses first the requirements for programmes and services, such as understanding and knowledge of SRHR, reasonable accommodation, and involving young persons with disabilities in the design. The section then provides a high level overview of some key SRHR programmes and services in the ESA region and the extent to which they are accessible for young persons with disabilities.

5.8.1 Key requirements for SRHR programmes and services for young persons with disabilities

There are some key factors which affect the accessibility of SRHR services for young people with disabilities. These include:

1. Understanding and knowledge of SRHR
2. Reaching young persons with disabilities
3. Reasonable accommodation
4. Social, religious and cultural barriers to access
5. Social and behavioural change methods
6. Involvement of young persons with disabilities in design

³³⁹ UNCRPD, 2006, p4

³⁴⁰ ARASA, 2016

Other challenges that have hampered SRHR service provision to young persons with disabilities to date include lack of materials and equipment, and inadequately trained health care workers required. These issues have been discussed in other sections of this analysis and are all important considerations for future planning.

5.8.1.1 Understanding and knowledge of SRHR

In order to realise rights, a person must first understand those rights. Sex and sexuality are still largely considered taboo or uncomfortable subjects and as a result, many young people do not have a good understanding of what sex and sexuality are and their rights.³⁴¹ This situation is compounded for young persons with disabilities where other people often make judgments or decisions regarding what a person with disabilities should or does not need to know related to sex and sexuality. Programmes and services must therefore ensure young persons with disabilities have access to information and education on SRHR and the people who play a role in their SRHR, such as families and service providers, are also informed on the rights and needs of young persons with disabilities.

Comprehensive sexuality education (CSE)

While attendance at school, particularly secondary school, across ESA is less than optimal, school remains the most likely place where young persons are educated about their SRHR.³⁴²

Through the years the approach to sexuality education in schools has shifted.³⁴³ Earlier versions of sexuality education for young people had a particular focus on abstinence education. More recently, best practices provide for a far more comprehensive provision of information in terms of contraception.³⁴⁴ In addition, there is a focus on gender and power and its influence on decision making in the space of sexuality. CSE is intended to allow learners to think critically about issues of gender, sexuality, their own rights and power; in addition to providing general information (content) on sexual and reproductive health. There is evidence that sexuality education programmes which address issues of gender and power are more effective in improving SRH outcomes.³⁴⁵

There are a number of stakeholders involved in providing CSE. UNESCO and UNFPA are currently supporting ESA countries in the roll out of CSE in schools. This project has been in progress for four years and in a relatively short timeframe it has helped to achieve political support for CSE, a review of the school curricula in many African countries and trained a number of teachers across the region³⁴⁶.

³⁴¹ UNESCO, 2016

³⁴² UNESCO, 2016

³⁴³ Haberland et al., 2014

³⁴⁴ UNESCO, 2016

³⁴⁵ UNESCO, 2016

³⁴⁶ UNESCO, 2016

At least nine countries (Lesotho, Malawi, Mozambique, Namibia, South Sudan, Swaziland, Tanzania, Uganda and Zambia) have gone through a process of revising their school curriculum to include elements of CSE. UNESCO, in collaboration with their partners, has developed the 'International Technical Guidance on Sexuality Education' (ITGSE) which provides guidelines for a fully comprehensive sexuality curriculum that is age appropriate. UNESCO and UNFPA have supported ESA country governments in revising their curricula in accordance with these guidelines. However, there is no guidance available on how to provide CSE to young persons with disabilities.³⁴⁷

Going forward, it is anticipated that the lessons learnt and momentum gained in the first four years of the project will facilitate further roll out of CSE in the region. While the outlook for CSE in the region is positive, there is a lack of disability-specific CSE to date.³⁴⁸ The current project scope does not include a focus on disabilities or an intention to review the content of the curriculum and how it might need to be adjusted for the needs of persons with disabilities.

Teaching and study materials provided under the current project are not customised to suit young persons with disabilities, particularly sensory disabilities such as provision of appropriate materials for visually impaired students³⁴⁹. A study in KwaZulu-Natal, South Africa collected data from 99 teachers across ten schools representing four types of disabilities³⁵⁰. The researchers used scales to investigate practices and beliefs in teaching sexual education and found that overall, teachers had positive attitudes towards teaching all elements of CSE. The teachers also mentioned however, that they were more comfortable to discuss 'soft topics' such as personal skills i.e. hygiene than they were to talk about sexual behaviour and functions. They mentioned that this was because their 'professional preparation and materials' were not adequate to provide quality sexuality education to their learners.³⁵¹ Subsequently, materials have been developed to build educator's capacity to deliver sexuality education to learners with disabilities. In line with the principles of the UNCRPD, these materials use a whole-school approach to include and respond to the needs of a diverse set of learners.

As CSE becomes more accessible within schools in the ESA region, this increases the potential for YPDW attending school to be exposed to some form of CSE. While it may be a generalised curriculum which doesn't necessarily take into account young persons with disabilities and their specific needs, it's once again preferable to no access to CSE.

³⁴⁷ Save the Children International, 2016

³⁴⁸ UNESCO, 2016

³⁴⁹ UNESCO, 2016

³⁵⁰ Chirawu et al, 2014

³⁵¹ Chirawu et al, 2014

5.8.1.2 Reaching young persons with disabilities

Another important factor in planning services and programmes is an understanding of how best to reach young persons with disabilities.

Using schools to reach young persons with disabilities

Young persons with disabilities are aged 10-24 and therefore school is a first consideration for being able to reach this target group with SRHR programmes and refer to services.

Some countries in the ESA region provide for young persons with disabilities, depending on the disability type and degree, with specialised schools. Other countries, however, have all children regardless of disability attend mainstream schooling. There are some obvious advantages of having specialised schools which can offer tailored education and support to young persons with disabilities. However, providing for young persons with disabilities in mainstream schools is more in line with the UNCRPD principles.³⁵²

However, young persons with disabilities are less likely to access to schooling than their counterparts.³⁵³ Most countries, provide for persons with disabilities and their rights to access education. Therefore, most countries make it compulsory for all children, including children with disabilities to attend school. However, attendance of children with disabilities at school continues to present challenges. These challenges include:

- The costs associated with attending school, including any associated learning devices or support. Even in countries where education is free there are other costs such as uniforms, books, and transport, which hinder the ability of young persons with disabilities, who mostly commonly live in poverty to attend.
- Travel for young persons with disabilities is both costly and challenging to access. Some students walk or ride bicycles many kilometres to school, particularly those who live in rural areas. This introduces additional challenges for students with disabilities who need to be accompanied to school or provided alternative transport (i.e. motor vehicle).
- Due to both costs and unavailability, appropriate materials for persons with disabilities also hinders the accessibility of education for some young persons with disabilities, for example, lack of textbooks or other materials printed in braille for visually impaired students.
- The skills of teachers, particularly in mainstream schools, introduces further challenges for young persons with disabilities. This is particularly true for teachers dealing with students who are hearing impaired, visually impaired or struggling with intellectual disabilities.

³⁵² UNCRPD, 2006

³⁵³ UNESCO, 2014

- Schooling infrastructure introduces significant challenges for young persons with disabilities. Little provision is made to ensure accessibility to buildings by students using walking aids or by those who are visually impaired.
- Finally, the social stigma surrounding persons with disabilities is probably the largest barrier to their access to education. In some instances, families will isolate the person with disabilities from society and therefore prevent their access to education. Further to this, in some countries there is the perception that a person with disabilities has no potential to contribute as a member of society and, therefore, investment in their education is a waste.
- Increased economic vulnerability of households with children with disabilities: A South African study using census, GHS and pilot data highlighted that households with children with disabilities are economically the most vulnerable with the lowest income while experiencing high cost, leaving no resources available to support education or health care

A report by the Secretariat of the African Decade in 2007, estimates that 80% of children with disabilities do not attend school. This has important implications for both inclusion strategies as well as for designing programmes that will reach young persons with disabilities in the short term. Among young persons with disabilities who do attend school, there is a very high dropout rate, particularly as they transition to secondary school. In Tanzania, for example, only 7% of student with disabilities progress onto higher levels of schooling³⁵⁴, while in Malawi 86.7% of youth with activity limitations do not attend high school. Similarly, in Lesotho and Malawi, where primary school enrolment of children with disabilities is on the higher end (74% and 64% respectively), only 15% and 13% (respectively) of those children progress to secondary school.

Reaching out-of-school young persons with disabilities

Given that a substantial number of young persons with disabilities do not attend school, it is important to plan programmes which focus on out-of-school means of reaching their target beneficiaries.³⁵⁵

Programmes focusing on out-of-school youth typically work through community-based or faith-based organisations. They may provide parent or community sensitisation or awareness training on the rights and needs of young persons with disabilities or SRHR more broadly. Successful community strategies target influential community and traditional leaders first, as these individuals can be ‘gatekeepers’ to communities and can be powerful ambassadors once they understand and buy into the programme objectives. In some instances, it is necessary to understand the community perspective on an issue and adapt the message accordingly. For example, efforts to increase the provision of CSE across ESA have noticed

³⁵⁴ National Bureau of Statistics, 2008

³⁵⁵ Programmes and initiatives to ensure children with disabilities attend school are out of the scope of the situational analysis which is part of a regional strategy to increase access to SRHR services.

that in many countries the programme is more fully embraced when it is shown to decrease child marriage. This helps to combat the misperception that CSE will lead to increased sexual activity among young people and instead relates directly to a community goal³⁵⁶.

Other methods that can be used to target out-of-school young persons with disabilities include radio and other media. Communication methods and channels must be considered against different types of impairments, for example ensuring appropriate communication methods and channels for young people with hearing disabilities, who are visually impaired or who otherwise cannot access social or other media.

Save the Children Sweden are also implementing a youth sexuality programme in the ESA region.³⁵⁷ The programme is implemented through civil society organisations and community and faith based organisations in nine ESA countries: Côte d'Ivoire, Ethiopia, Kenya, Nigeria, Senegal, Swaziland, Zambia and Zimbabwe. Since the programme is implemented through community based organisations, it has the potential to reach youth who are not in school. This is particularly relevant for children with disabilities since many children with disabilities in ESA are not in school.

5.8.1.3 Reasonable accommodation

The UNCRPD obligates member states to take appropriate measures to ensure persons with disabilities have access, on an equal basis with others, to the physical environment, transportation, and other facilities and services open or provided to the public, both in urban and in rural areas.³⁵⁸

The Convention requires member states to ensure that service providers (including public and private) provide "reasonable accommodation" for persons with disabilities. Reasonable accommodation means undertaking necessary and appropriate modifications and adjustments to facilities, which do not impose a disproportionate or undue burden on the service provider, in order to ensure that persons with disabilities can access the facility on an equal basis to persons without disabilities.³⁵⁹ The concept of universal design also applies to service delivery. Specifically, the Convention requires health services to be provided as close as possible to people's own communities, including in rural areas.³⁶⁰

Generally speaking, physical access to health care facilities for persons with disabilities are insufficient, particularly in rural areas. In the instances where healthcare facilities are reasonably located, persons with disabilities experience many challenges hampering their inclusion and access to health care. The most prominent barrier to access is the lack of

³⁵⁶ UNESCO, 2016

³⁵⁷ UNESCO, 2016

³⁵⁸ UNCRPD, 2006, p8

³⁵⁹ UNCRPD, 2006, p4

³⁶⁰ UNCRPD, 2006, p16

physical access due to inappropriate infrastructure and limited possibilities for transportation.³⁶¹

Clinics and hospitals are not always physically accessible for persons with disabilities. The infrastructure may be inappropriate for person with walking aids. There may be no provisions made for people with visual or hearing impairments.

In addition, transportation is a challenge for many living in Africa, regardless of disability. Disabled Africans are faced with further challenges. Not only are they likely to have to pay more for transportation, they may also be limited for transport options. Many people living in rural areas are required to travel long distances to access healthcare services. Many healthcare facilities, particularly larger ones, or those offering more specialised services, are often located in more urban areas.

Another factor of reasonable accommodation is the ability for service providers and young persons with disabilities to communicate. Communication includes physical communication, through language, as well as signs, materials and other printed or audio methods to provide information. Some of the communication challenges that affect young persons with disabilities when trying to access services have already been described in previous sections.

In many countries, sign language is still developing and lacks many words and phrases related to SRHR. Some of these words include fertilisation and condoms. This can lead to misinterpretation and misinformation among the deaf community, restricting their access to SRHR. In Kenya, a new company, Deaf eLimu Plus (DEP), has pioneered educational products and tutorial services in sign language. Supported by Nailab and UNFPA in the country, DEP have developed the Sex eLimu Sign Language App.³⁶² The application functions as a dictionary where the word can be entered into the app and a video demonstrates how to sign the word. Information is relayed through video stories and descriptions.³⁶³

It is important that all young people, not just young persons with disabilities, are able to access SRHR in a language and level of complexity they are comfortable and able to communicate in.

5.8.1.4 Social, religious and cultural barriers

Social and cultural issues are likely to offer one of the biggest barriers to YPWDs to accessing SRHR services. The UNCRPD specifically recognises the role that attitudes play towards a person's experience of their disability, stating that *"disability is an evolving concept...[that] results from the interaction between persons with impairments and*

³⁶¹ WHO, 2011 and UNFPA, 2016

³⁶² Deaf eLimu Plus Kenya, no date

³⁶³ UNFPA, 2016c

*attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”.*³⁶⁴

There are a number of social and cultural challenges faced by young persons with disabilities with respect to accessing their SRHR, including:

- There are a number of myths around SRHR in general. These myths are held by people with and without disabilities and are perceptions of people with and without disabilities. The nature of SRHR itself is complex and social and cultural attitudes and myths create further complexity.
- There are a number of myths and misperceptions on the sexuality of young people and a commonly held belief that young people should not be sexually active or that they are over-sexed.
- There are social and cultural perceptions that persons with disabilities should be asexual or non-sexual and should not reproduce to prevent their disability from being ‘passed on’ to the next generation. In addition, there are some misperceptions that persons with disabilities are incapable of raising children.
- As a result of an overall lack of understanding, such beliefs and attitudes are held by the general public, service providers such as healthcare and education professionals, and even persons with disabilities themselves

The UNCRPD sets out a number of obligations for member states to raise awareness on the rights of persons with disabilities under Article 8, including through the use of public awareness campaigns. These include:

- Raising awareness throughout society, including at the family level, to foster respect for the rights and dignity of persons with disabilities;
- Combatting stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
- Promote awareness of the capabilities and contributions of persons with disabilities to society as a whole.³⁶⁵

The attitudes of healthcare workers have shown to be a deterrent to many individuals wanting to access any healthcare services. There are a number of factors which have been described to impact on the attitudes of healthcare workers, these include being overworked, poor job satisfaction³⁶⁶, moral judgements and cultural norms amongst others.

Accessing SRHR services, which is already intimidating for many, is even more challenging because of the added potential for moral, religious and cultural norms to influence

³⁶⁴ UNCRPD, 2006, p1

³⁶⁵ UNCRPD, 2006, p7

³⁶⁶ Ibrahim, 2017

perceptions. Added to this, the experience of young people and people with disabilities is even more challenging.

5.8.1.5 Social and behaviour change communication methods

Social and behaviour change communication (SBCC) is a framework for that uses the strategies of advocacy, social change communication and behaviour change communication to create positive health outcomes, such as SRHR outcomes.

Social change focuses on the community as a unit of change and is used as a process of redistributing power within social and political institutions. Behaviour change is a research-based consultative process for addressing knowledge, attitudes and practices. This approach focusses on the individual as a locus for change.³⁶⁷

SBCC strategies and programmes for SRHR are operational across the ESA region, however documentation of the actual programmes is limited.³⁶⁸ Documentation such as the theory of change and evaluations of the programmes are not readily available. Whether this is because evaluations are not regularly funded or because they are not put into the public domain is unclear. Therefore, it is difficult to determine whether the existing programmes are in fact meeting their objectives and creating the necessary impact.

SBCC in the ESA region typically places specific focus on HIV prevention. SBCC often focuses on a very specific target audience. Therefore, messages are tailored very specifically for that audience. There appears to be very little targeting of young persons with disabilities with messaging on SRHR. By default, there is an expectation that young persons with disabilities would be included as part of some of the targeted audiences because of their proclivity to be living in poverty, experiencing gender inequality, sexual violence and a lack of education. This may be a false assumption. Even if young persons with disabilities are included within the audiences, they may be exposed to general messaging for these audiences but no 'disability-specific' messaging. Two examples of relevant programmes include the Handicap International *Making it Work* programme and the South African Medical Research Council *Breaking the Silence* project (formerly known as *HEARD*).

Where disability is specifically addressed in SBCC, it often relates to upholding the rights of persons with disabilities quite generally. There are also communications which deal with persons with disabilities as victims of sexual abuse and violence. However, there is little evidence that persons with disabilities are acknowledged as sexual beings, who have sexual needs and desires just like any other person.

³⁶⁷ UNICEF, 2017

³⁶⁸ Some of these strategies and programmes are discussed later in this section.

5.8.1.6 Inclusion of young persons with disabilities in design

One of the other factors contributing to the limited support and health information for people with disabilities is the fact that in part, persons with disabilities and young persons with disabilities have not been included in the design and development of services provided to communities and thus their service requirements are not well articulated.³⁶⁹ It is important that service and programme design is based on consultation with young persons with disabilities. Young persons with disabilities can also be included as peer researchers and peer educators, a common approach for SRHR programmes to raise awareness of rights and disseminate information.

5.8.2 Key SRHR services

There are a broad range of SRHR services, which were discussed in a previous section of this report. For ease of reference, the table below lists some of these services. This section describes key SRHR services and the specific considerations for young persons with disabilities.

Table 14: SRHR services

Service group	Types of services
Cross cutting	<ul style="list-style-type: none"> • Comprehensive sexuality education
Family planning	<ul style="list-style-type: none"> • Contraceptive pills, injections, implants etc. • Intra-uterine devices (IUD) • Natural family planning • Male and female condoms • Diaphragm
Maternal healthcare	<ul style="list-style-type: none"> • Pre-natal and antenatal care • Child birth • Neonatal care • eMTCT (elimination of Mother to Child Transmission)
Preventing and managing gender-based violence	<ul style="list-style-type: none"> • Rape kits • Counselling and support • Other relevant medical treatment
Preventing and treating sexually transmitted diseases	<ul style="list-style-type: none"> • HIV counselling and testing (HCT) • HPV vaccines • Pap smears • Circumcision • Provision of drugs for treatment e.g. Antiretroviral drugs (ARVs)
Other reproductive health	<ul style="list-style-type: none"> • Mammograms • Screenings for male cancers (testicular, prostate etc.)

This section describes the various SRHR services in more detail, providing data where possible. However, where data is available it is consistently not disaggregated for persons with disabilities so the quantified uptake of services by young persons with disabilities is not

³⁶⁹ UNAIDS, 2014

known, even where we may be aware of issues and barriers to access. Across all SRHR services, data needs to be disaggregated for gender, age and disability.

Comprehensive sexuality education is described later in this section, under programmes.

5.8.2.1 Testing and treatment

Although HIV testing and treatment services have been integrated into routine public health processes, challenges are still prevalent. Some of these challenges include inadequate tracking of patients, weak monitoring and evaluation systems, stock-outs as a result of incomplete drug and diagnostic intelligence, insufficient funding and overburdened health workers.

In recent years, there has been an increase in HIV testing and counselling (HTC) services. The concept of “test and treat” is part of the 90:90:90 strategy introduced by the UN. The goal is that by 2020, 90% of people who are HIV infected will be diagnosed, 90% of diagnosed persons will be on antiretroviral treatments and 90% of those persons on antiretroviral will be virally suppressed. If people can be identified earlier on in their infection, treatment can begin earlier and thus the transmission of HIV/AIDS will be prevented.³⁷⁰

In Malawi, HTC services are offered through two methods: client-initiated HTC and provider-initiated HTC. Testing is administered in a number of different ways such as static sites, mobile testing units, home-based testing and national HTC events.³⁷¹ In 2013, Tanzania introduced a new approach to HIV testing. This included home-based testing and community testing.³⁷² Home-based testing was also implemented in South Africa. Pharmacies began stocking HIV ‘take home’ testing kits in 2015.³⁷³

These alternative methods provide additional options for young persons with disabilities to access HIV testing products which may be preferable to them. Home-based testing allows young persons with disabilities to purchase kits and test themselves in the privacy of their own homes. One programme in Kenya focuses on providing HCT specifically to the hearing impaired community. The services offered include: confidential HCT at clinics managed by deaf staff; mobile HCT activity and community mobilisation in urban and rural deaf communities; support to deaf clients in need of referral and care; establishment of post-test support groups within deaf communities; and development of communication materials.³⁷⁴ However, HCT services specifically catering to the needs of young persons with disabilities are not systematic across the region.

³⁷⁰ The Conversation Africa, 2016

³⁷¹ Malawi Ministry of Health

³⁷² Tanzania Ministry of Health, 2014

³⁷³ Daily Maverick, 2017

³⁷⁴ GIZ Health Sector Programme, 2013

5.8.2.2 eMTCT

ESA countries have realised significant progress in the prevention and elimination of mother-to-child transmission (eMTCT). Between 2010 and 2011, the coverage of services to eliminate mother-to-child transmission within the region increased from 61% to 72% respectively. South Africa has been at the forefront of eMTCT and, by 2009, HIV testing for pregnant women in the country was estimated to be almost universal.³⁷⁵ Other countries have also had similar successes. Botswana, Zambia and Zimbabwe have exceeded 90% coverage of HIV testing and counselling among pregnant women 2010.³⁷⁶

However, there are still countries in the region, such as Angola and Ethiopia, which continue to experience challenges in achieving eMTCT. Less than one in three women in these countries took an HIV test during their pregnancy in 2010.³⁷⁷ This can be attributed to lack of eMTCT services and testing products provided at antenatal care facilities in these countries as well as poor access and use of these services.

Data was not available on the number of women with disabilities who have access to eMTCT. This missing of data is due to the lack of disaggregated data for women with disabilities accessing eMTCT services.³⁷⁸ It is important to understand whether having a disability affects the ability to be tested and prevent transmission, in order to ensure that women with disabilities are not more vulnerable to transmission.

5.8.2.3 HPV vaccinations

Since 2011, some countries in Africa (Rwanda, Uganda, Seychelles, Lesotho, and South Africa) have introduced a publicly funded national human papillomavirus (HPV) vaccination programme. In southern Africa, almost all vaccinated females were in the younger age group (aged 10–14 years).³⁷⁹ However, as there is no disability indicator used in the data, it was not possible to understand the number of girls with disabilities who received the vaccination.

Table 15: Estimated number of vaccinated females and human papillomavirus vaccine coverage in Africa by October, 2014

	Number of vaccinated females (millions)	Coverage among the total female population		Coverage among the targeted population (all ages)	
		All ages	Aged 10–20 years	All	Primary target and organised catch-up
Full-course vaccination by geographical region	1.6 (0.9–2.6)	0.3% (0.2–0.5)	1.2% (0.7–2.0)	88.0% (46.5–100.0)	88.0% (46.5–100.0)

³⁷⁵ Barron et al., 2013. P91:7–74.

³⁷⁶ WHO, UNAIDS, UNICEF, 2010

³⁷⁷ WHO, UNAIDS, UNICEF, 2010

³⁷⁸ UNICEF, 2012

³⁷⁹ Bruni et al 2016

	Number of vaccinated females (millions)	Coverage among the total female population		Coverage among the targeted population (all ages)	
		All ages	Aged 10–20 years	All	Primary target and organised catch-up
One-dose vaccination by geographical region	1.6 (0.8–2.7)	0.3% (0.1–0.5)	1.2% (0.6–2.0)	85.2% (40.9–100.0)	85.2% (40.9–100.0)

Source: Bruni, L, Diaz, M, Barrionuevo-Rosas L, Herrero R, Bray F, Bosch FX, de Sanjosé S, Castellsagué, X, 2016 'Global estimates of human papillomavirus vaccination coverage by region and income level: a pooled analysis'. *The Lancet Global Health*, Volume 4 , Issue 7 , e453 - e463

GAVI, the Vaccine Alliance, supports projects which work to roll out vaccinations in developing countries (mostly in sub-Saharan Africa).

5.8.2.4 Abortion

Abortion is illegal in most African countries. As a result, safe abortion services are not offered and women and girls who wish to access such services will seek out illegal services which place the women's health and often her life in danger. It is estimated that more than one in three women who access unsafe abortion services will experience major complications.³⁸⁰ Further to this, post abortion services are of poor quality. The lack of trained healthcare workers, the use of inappropriate procedures and judgmental attitudes of healthcare workers all contribute towards this poor quality of services³⁸¹.

South Africa, Zambia and Ethiopia are the only countries in the ESA region which provide legal abortions with few limitations³⁸². Other countries may offer abortions under certain circumstances, usually to save the life of the mother or in cases of rape, incest or foetal impairment. Angola, DRC and Madagascar do not allow for abortions under any circumstances.³⁸³ Data on the number of women and girls with disabilities who have accessed safe and unsafe abortions was not available.

5.8.2.5 Medical Male Circumcision

Medical male circumcision (MMC) reduces the risk of female-to-male sexual transmission of HIV by approximately 60%³⁸⁴. Roll out of MMC is receiving attention from ministries of health throughout Africa as they make attempts to ensure that men have partial protection from HIV infection.³⁸⁵

³⁸⁰ Guttmacher Institute, 2015

³⁸¹ Guttmacher Institute, 2015

³⁸² Guttmacher Institute, 2015

³⁸³ Guttmacher Institute, 2015

³⁸⁴ WHO, 2012

³⁸⁵ WHO, 2012

The prevalence of male circumcision is wide ranging in the ESA region. There are a number of countries with large Muslim populations, this influences the prevalence of circumcision significantly. Prevalence ranges from as low as 1.1% in the Seychelles to 98% in the DRC and Eritrea³⁸⁶. It is however, important to consider that many religious and cultural circumcision may not meet the standards of MMC. Therefore, prevalence data of MMC needs to be improved. In addition, data on the prevalence of circumcision amongst men with disabilities does not appear to be available.

5.8.3 Key SRHR programmes

This section describes key SRHR programmes in ESA and the extent to which they are specific and/or relevant to young persons with disabilities. From the literature available for this situational analysis, there appears to be only one programme specific to the SRHR needs of young persons with disabilities. Other programmes may include young persons with disabilities to the extent they are part of the general population being targeted (e.g. to the extent young persons with disabilities are attending school). However, there is significant risk and emerging findings that these programmes do not sufficiently consider or accommodate the needs of young persons with disabilities without a specific focus on this population.

5.8.3.1 WE DECIDE: Young persons with Disabilities. A Programme for Equal Opportunities and a Life Free of Violence

WE DECIDE, a programme by the UNFPA, is focused on access to SRHR services, information and education for young people living with disabilities, including the prevention of sexual gender-based violence.

The programme includes a promotional campaign to prevent sexual violence against young persons with disabilities, including SRHR and social inclusion policies developed and implemented worldwide. The programme is in its early stages and continues to evolve as it's implemented and informed by relevant information. Some other initiatives include: *Breaking the Silence*, a South African Medical Research Council initiative, a caregiver intervention by Africa Tikkun and a Save the Children programme for survivors of sexual violence.

³⁸⁶ Morris et al., 2016

5.8.3.2 Soul City

The Soul City Institute for Health and Development Communication is a South African based health and development communication organisation which has partnerships in the ESA region to implement behaviour change programmes. Currently the Soul City Institute runs programmes in South Africa and other African countries as follows:

- Namibia: Desert Soul
- Lesotho: Phela
- Swaziland: Lusweti
- Mozambique: Nweti
- Zimbabwe: Action Pals
- Zambia: Kwatu
- Malawi: Pakachere
- Tanzania: Femina Hip

The regional partnerships focus on the effective development and dissemination of social behaviour change communication at country level to create awareness of SRHR and its link to HIV.³⁸⁷ Soul City programmes address a wide range of issues related to SRHR including HIV and AIDS, GBV, other STIs, family planning amongst others. Soul City programmes are not specific to young persons with disabilities and the extent to which they are able to support behavioural change among or about young persons with disabilities is not documented in the literature.

5.8.3.3 DREAMS

DREAMS is a programme targeting adolescent girls and young women in Lesotho, Kenya, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe³⁸⁸. The programme aims to reduce HIV infections amongst the young women and address social and structural constructs impacting of risk of HIV. These include poverty, gender inequality, sexual violence, and a lack of education. Young women with disabilities do not appear to be a specific target of the programme, however, their predisposition to poverty, gender inequality, sexual violence and lack of education should include them to a certain extent within the target population of the programme³⁸⁹.

³⁸⁷ The Communication Initiative Network, 2017

³⁸⁸ HIVSA, 2016

³⁸⁹ HIVSA, 2016

5.8.3.4 Global Programme to Enhance Reproductive Health Commodity Security

The UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRCS) is a thematic programme dedicated to the improving access to reproductive health. This was the first UN programme for reproductive health commodity security. It aims to ensure greater access to contraceptives, condoms, equipment and medicine for family planning, HIV/STI prevention and maternal health services. The programme is focused on the following:

- Mobilising political and financial commitment to enable the environment
- Strengthening national health systems and services through capacity development
- Procuring reproductive health commodities

In 2016, this programme helped over 12.5 million women in more than 46 countries to receive access to reproductive health services.³⁹⁰

5.8.3.5 CONDOMIZE!

CONDOMIZE! Is a joint programme of the UNFPA, in partnership with UNAIDS and the Condom Interagency Task Team. The programme aims to reduce the stigma associated with condoms and facilitate global access to quality condoms, education and community mobilisation. The programme targets the general population, with a particular focus on youth. There is however, no specific targeting of persons with disabilities.³⁹¹ If there are specific efforts to ensure that PWDs have access to condoms through this programme.

5.8.3.6 DHAT livelihood and SRHR activities

The Disability, HIV and AIDS Trust (DHAT) has initiated a series of income generating activities, acknowledging that persons with disabilities are particularly vulnerable to poverty and exclusion from the formal labour market and can also be restricted from informal economic opportunities.

A number of initiatives in Zimbabwe were coordinated by DHAT and local civil society and community organisations to support livelihoods of persons with disabilities. These activities provide the opportunity to transfer information regarding SRHR. To date the initiative has demonstrated reduced stigma and discrimination, increased knowledge and information, and improved economic situation of individuals.

³⁹⁰ UNFPA, 2017

³⁹¹ UNAIDS, 2016

5.8.3.7 Brothers for Life

Brothers for Life is a social change programme run in South Africa. The programme is supported by the Department of Health, the South African National AIDS council (SANAC), USAID and PEPFAR. It is one of the few programmes focusing specifically on men and how they influence issues such as GBV and sexual norms. The aim of the programme is to promote positive male norms and encourage the uptake of health services such as Medical Male Circumcision (MMC), HIV Testing, Consistent condom use and reduction of sexual partners. In addition a key focus of the campaign is to mobilise men to actively address GBV in their communities. The specific inclusion of men with disabilities and focus on women with disabilities is not known from the available information.

5.8.3.8 Support to carers/psychosocial programmes

Psychosocial support programmes are also important in the context of ensuring SRHR. Such programmes should also consider the carers of young persons with disabilities, and provide them with psychosocial support but also information on SRHR and particularly the rights of young persons to enjoy their rights. Uganda has established parent support groups, such as the National Association of Parents of Deaf Children, for adolescents with disabilities which specifically focus on reproductive health.

5.8.3.9 Awareness raising

The International Day for Persons with Disabilities, as well as some country specific days, weeks or months, dedicated to raising awareness around a specific disability; are often used as the vehicle for communicating messages regarding disabilities.

In addition, some regional associations such as DHAT, the Disability Networking Zone and the Africa Campaign on Disability and HIV/AIDS have awareness campaigns to promote access to services, and reduce stigma and discrimination.

However, there is limited evidence that these awareness raising efforts pay any attention to the SRHR issues of persons with disabilities.

6 References

African Youth and Adolescent Network on Population and Development, 2017. [Online] Available at: <http://youthleadglobal.org/afriyan/> . Accessed 17 June 2017

African Youth Parliament, 2011 “Democracy and Governance Network-Africa” [Online] Available: <http://www.comminit.com/governance-africa/content/african-youth-parliament-ayp>. Accessed: 17 June 2017

Ahumuza, S.E.; Matovu, J.K.B.; Ddamulira, J.B.; Kyoheirwe, F. 2014. Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda *Reproductive Health* 2014, 11:59 <http://www.reproductive-health-journal.com/content/11/1/59>

Alemu T and Fantahun M., 2011 Sexual and reproductive health status and related problems of young people with disabilities in selected associations of people with disability, Addis Ababa, Ethiopia. *Ethiop Med J.* 49(2):97-108.

Amnesty International USA, no date. Sexual and Reproductive Rights Fact Sheet. <http://www.amnestyusa.org/pdfs/SexualReproductiveRightsFactSheet.pdf>

Ayiga N. and Kigozi, S. (2016). Access to and Uptake of Contraception by women with disabilities. *Journal of Social Sciences* 2016, 12 (4): 171.181

AYWDN, 2013. “Access to Sexual Education and Health Services”. [Online] Available at: <http://aywdn.org/networking/>. Accessed 18 May 2017

Banks, LM, Mearkle, R, MacTaggart, I, Walsham, M, Kuper, H, Blanchet, K, 2015. Disability and social protection programmes in low- and middle-income countries: a systematic review. *Oxford Development Studies.* pp. 1-17

Barron P, Pillay Y, Doherty T, et al. Eliminating mother-to-child HIV transmission in South Africa. *Bull World Health Organ* 2013;91:70-7

Beatrice, G., 2014. The state of Access to Education By Women & Girls with Disabilities: The Case of Uganda. [Online] Available: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwitzc7-w97UAhUCWBQKHQTrB50QFggnMAA&url=http%3A%2F%2Fwww.ohchr.org%2FDocuments%2FHRBodies%2FCEDAW%2FWomensRightEducation%2FNationalCouncilForDisabilityUganda.doc&usq=AFQjCNGb_uWzBAKENziPsedmzHfpvhYkw

Brown, H., 2010. “Sexual abuse of children from Sexual Violence: A comprehensive approach – Chapter 7: Sexual abuse of children with disabilities”

Bruni, L, Diaz, M, Barrionuevo-Rosas L, Herrero R, Bray F, Bosch F X, de Sanjosé S, Castellsagué, X, 2016 'Global estimates of human papillomavirus vaccination coverage by region and income level: a pooled analysis'. The Lancet Global Health , Volume 4 , Issue 7 , e453 - e463

Capana, A., 2016. Sexual and Reproductive Rights, Geneva Foundation for Medical Education and Research, Mozambique Constitution. [Online]. Available: <http://www.gfmer.ch/srr/Mozambique.htm>. [Accessed 03 February 2016].

Capasso, A., 2016. "WE DECIDE: Young persons with Disabilities: Equal Rights and a Life Free of Violence. Management Science for Health (MSH). Available online: <https://www.msh.org/blog/2016/08/12/we-decide-young-persons-with-disabilities-call-for-equal-rights-and-a-life-free-of>

Casimiro, E., & Lopes, U., 2013 1 Africa Disability Right yearbook. Pretoria, South Africa. Volume 1 2013

Centre for Reproductive Rights, 2017. Capacity and consent: empowering adolescents to exercise their reproductive rights. New York.

Chilemba, EM., 2015. 'Disability rights and emerging disability legislation in selected African jurisdictions: A diagnostic commentary' (2015) 3 African Disability Rights Yearbook: 291-308

Chirawu. P, Hanass-Hancock. J, Aderemi. TJ, de Reus. L, Henken. AS, 2014. "Protect or Enable? Teachers' Beliefs and Practices Regarding Provision of Sexuality Education to Learners with Disability in KwaZulu-Natal, South Africa"

Clifford, G and Franceschi, S, 2005. HPV in sub-Saharan Africa, Papillomavirus Report, 16:5, 322-326, DOI: 10.1179/095741905X49089

Constitution of Botswana, 1966.

Constitution of Mozambique, 2004

Daily Maverick, 2017, Health-e News: DIY test for HIV comes to a pharmacy near you. [Online] Available: <https://www.dailymaverick.co.za/article/2017-01-15-health-e-news-diy-test-for-hiv-comes-to-a-pharmacy-near-you/#.WI8zBBE0Pug>

Deaf eLimu Plus Kenya, no date. Available online: <https://deafelimuplus.co.ke/>

Disability Rights Education & Defence Fund. 2017 "National Disability Council".[Online] Available at: <https://dredf.org/legal-advocacy/international-disability-rights/international-laws/namibia-national-disability-council-act/> . Accessed: 16 June 2017

Draft National Youth Policy, 2015. Government Gazette 38393, Notice 15 of 2015, 12 January 2015.

EAC, 2012. "Strategic Plan for Gender, Youth, Children, Persons with Disability, Social Protection and Community Development, 2012 – 2016"

Education Development Trust, 2016. A study on children with disabilities and their right to education: [Online] Available: <https://www.unicef.org/esaro/Madagascar-children-with-disabilities-UNICEF-EDT-2016.pdf>

Eide, A.H., Jele, B. 2011. Living Conditions among People with Disabilities in Swaziland (2011). [Online] Available: https://www.sintef.no/globalassets/upload/samfunn/finalreportlc_swasilandweb.pdf

El-Sadr WM, Rabkin M, Atun R, De Cock KM, 2011, Bridging the Divide Introduction, *J AIDS-Journal of Acquired Immune Deficiency Syndromes*, Vol: 57, Pages: S59-S60, ISSN: 1525-4135

EuropeAid, 2017. "Health care and training". [Online] Available at: http://ec.europa.eu/europeaid/documents/case-studies/acp_health-care_en.pdf. Accessed: 20 June 2017

European Commission, 2016. Report from the commission to the European Parliament and The Council: 2016 Annual Report on the implementation of the European Union's instruments for financing external actions in 2015. [Online] Available: http://ec.europa.eu/europeaid/sites/devco/files/annual-report-2016-com2016-810_en.pdf

Frohman, C. & Ortoleva, S, 2013. Issues paper: The Sexual and Reproductive Rights of Women and Girls with Disabilities. International conference on human rights 1 July 2013.

GIZ Health Sector Programme, 2013. "Liverpool VCT Care and Treatment (LVCT), Kenya".

Gott, M., Hinchliff, S., & Galena, E, (2004). General practitioner attitudes to discussing sexual health issues with older people, *Social Science and Medicine*, 58, 2093-2103.

Government of Lesotho, 2006. National HIV and AIDS Policy. [Online]. Available: <http://www.saf aids.net/files/LesothoNational%20HIVandAIDS%20Policy2006.pdf> [Accessed 27 June 2017].

Government of Lesotho, Ministry of Health and Social Welfare, 2015. National policy on vulnerable children. [Online]. Available: <http://www.riatt-esa.org/resources-page-holder/2015/5/12/lesotho-national-policy-on-orphans-and-vulnerable-children> [Accessed 27 June 2017].

Government of the Netherlands, 2011a. [Online]. Available: <https://www.government.nl/ministries/ministry-of-foreign-affairs/contents/policy-and-budget/foreign-affairs-budget-2011-2012> [Accessed 26 July 2017]

Government of the Netherlands, 2011b. Letter to the House of Representatives presenting the spearheads of development cooperation policy. [Online] Available: http://www.minbuza.nl/binaries/content/assets/minbuza/en/import/en/key_topics/development_cooperation/dutch_development_policy/parliamentary-letter-of-march-18-2011-presenting-the-new-focus-of-development-cooperation-policy [Accessed 26 July 2017]

Government of the United Kingdom, 2016. Department for International Development Annual Report and Accounts 2015–16. [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538878/annual-report-accounts-201516a.pdf [Accessed 26 June 2017]

Government of Zimbabwe, 2013. Ministry of Youth Development, Indigenisation and Empowerment. National Youth Policy. [Online]. Available: <http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjn39ia7d3UAhXHCsAKHQWqBcsQFggjMAA&url=http%3A%2F%2Fnayoafrika.org%2Findex.php%2Fresources%2Fpolicy-documents%3Fdownload%3D10%3Azimbabwe-2013-national-youth-policy&usg=AFQjCNFPiE-rgII51CBtHKhesGF0d4IFfw> [Accessed 27 June 2017].

Government of Zimbabwe, 2014. Global AIDS Response Country Progress Report-Zimbabwe 2014. [Online] Available: http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2014.pdf [Accessed 27 June 2017].

Government of Zimbabwe, 2016. National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy. [Online]. Available: <https://drive.google.com/file/d/0B9-C8CiaTO-cTnJrN1ZkMW5FV1U/view> [Accessed: 27 June 2015].

Gray, G, 2016. HIV, AIDS and 90-90-90: what is it and why does it matter? *The Conversation Africa, Inc. 2016*

Gulliford, M., et al., 2002 "what does 'access to health care' mean?" *Journal of Health Services Research and Policy*. Jul 7(3): 186-8

Guttmacher Institute, 2015. "Facts on Abortion in Africa". [Online] Available at: https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_AWW-Africa.pdf . Accessed 20 June 2017

Guttmacher Institutes and UNFPA, 2014. Fact Sheet: Investing in Sexual and Reproductive Healthcare and Rights in sub-Saharan Africa. <https://www.guttmacher.org/sites/default/files/factsheet/fb-addingitup2014-ssa.pdf>

Haberland et al., 2014 Sexuality Education: Emerging Trends in Evidence and Practice' *Journal of Adolescent Health*

Halvorsen and Ibsen, 2015 Population Census Data – Angola; as cited in Tor Halvorsen and Hilde Ibsen (2015). Knowledge for a Sustainable World: A Southern African-Nordic contribution. http://www.africanminds.co.za/wp-content/uploads/2015/11/Knowledge_for_a_Sustainable_World-WEB.pdf

Hanass-Hancock, J., 2009. Interweaving conceptualisations of gender and disability in the context of vulnerability to HIV/AIDS, in *Sexuality and Disability*. DOI: 10.1007/s11195-008-9105-9

Handicap International, 2015. Annual Report 2015 Handicap International. [Online] Available: <https://www.handicap-international.org.uk/sites/uk/files/page/docs/2015-annual-report-handicap-international-federation-en.pdf> [Accessed 26 June 2017]

Hanass-Hancock, J., 2009: Interweaving conceptualizations of gender and disability in the context of vulnerability to HIV/AIDS in KwaZulu-Natal, South Africa. *Sexuality and disability*, 27(1): p. 35-47

HEARD, 2015. Lesotho Sexual and Reproductive Health and Rights. [Online] Available: <https://www.heard.org.za/wp-content/uploads/2015/10/lesotho-srhr-country-fact-sheet.pdf> [Accessed 27 June 2017].

HIVSA, 2016, DREAMS programme. [Online] Available: <http://hivsa.com/?q=content/dreams-programme>

Ibrahim, A, 2017. "Poor health worker attitude: Are the health workers solely to blame or do health policy decisions contribute as well to this poor attitude?" [Online] Available at: <http://ktnetafrica.net/blog/poor-health-worker-attitude-are-health-workers-solely-blame-or-do-health-policy-decisions> . Accessed 20 June

ILO, 2006. Malawi Country Profile. [Online] Available: <http://www.ilo.org/public/english//region/asro/bangkok/ability/download/malawi.pdf> [Accessed June 27 2017].

ILO, 2009. Inclusion of People with Disabilities In Uganda. [Online] Available: http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_115099.pdf

ILO, 2013. Inclusion of People with Disabilities in Ethiopia. [Online] Accessed: http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_112299.pdf [Accessed 27 June 2017].

International Disability Alliance (IDA), 2011. Sterilization of Women and Girls with Disabilities: A Briefing Paper. Available at: http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf

International Planned Parenthood Association, 2016. IPPF Financial Statements 2015. [Online] Available: http://www.ippf.org/sites/default/files/2016-06/Financial%20Statements_2015.pdf [Accessed 20 June 2017].

International Planned Parenthood Federation, 2017. [Online] Available at: <http://www.ippfar.org/news> . Accessed: 20 June 2017

International Planned Parenthood Federation, 2017. [Online] Available at: <http://www.ippf.org/our-results>. Accessed: 20 June 2017

IPPF, UNFPA, WHO, UNAIDS, 2012. Rapid Assessment of Sexual and Reproductive Health and HIV Linkages. [Online] Available: http://srhhivlinkages.org/wp-content/uploads/2013/04/ras_namibia_en.pdf [Accessed 27 June 2017].

Kassa TA, Luck T, Birru SK, Riedel-Heller SG. 2014. Sexuality and sexual reproductive health of disabled young people in Ethiopia.

Kassa, T.A., Luck, T., Bekele, A., and Riedel-Heller, S.G., 2016. Sexual and reproductive health of young people with disability in Ethiopia: a study on knowledge, attitude and practice: a cross-sectional study. *Globalization and Health* 2016;12:5.

Kassa, T.A, Luck, T, Bekele, A. and Riedel-Heller, S.G., 2016 Sexual and reproductive health of young people with disability in Ethiopia: a study on knowledge, attitude and practice: a cross-sectional study. *Globalization and Health* (2016) 12:5 DOI 10.1186/s12992-016-0142-3

Kissick, K. undated. "The Brain Drain: Migration of Healthcare Workers out of Sub-Saharan Africa". Available at: <http://med.stanford.edu/schoolhealtheval/files/KissickBrainDrainFactSheetFinal.pdf>.

Kotzé, H., 2012. Country Profiles Report: Southern Africa Disability Rights and Law Project. [Online] Available: https://issuu.com/osisa/docs/disability_open_learning_-_country_

Lewis D.A., 2011. HIV/sexually transmitted infection epidemiology, management and control in the IUSTI Africa region: focus on sub-Saharan Africa. *British Medical Journal*, Vol 87. Issue Suppl 2.

Lewis, H. 2013 'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia'. Women with Disabilities Australia (WWDA), Rosny Park, Australia. At: http://www.wwda.org.au/WWDA_Sub_SenateInquiry_Sterilisation_March2013.pdf

Losinio, L, 2016. "Empowering people with disabilities through assistive technology" available online: https://www.postguam.com/news/local/empowering-people-with-disabilities-through-assistive-technology/article_ac268bae-fe49-11e5-a42d-2f46a13b1626.html

MacPherson P, Laloo DG, Webb EL, Maheswaran H, Choko AT, Makombe SD, et al. Effect of optional home initiation of HIV care following HIV self-testing on antiretroviral therapy initiation among adults in Malawi: a randomized clinical trial. *JAMA*. 2014; 312(4):372–9.

Malawi Ministry of Health, undated. Scaling up HIV Testing and Counselling in Malawi.

Mall, S., & Swartz, L., 2012. Editorial: Sexuality, disability and human rights: Strengthening healthcare for disabled people. *South African Medical Journal*, Vol. 102, No. 10, October 2012.

Management Sciences for Health, 2017. [Online] Available: <https://www.msh.org/resources/we-decide-initiative-for-young-persons-with-disabilities-infographic> [Accessed 27 July 2017].

Mandipa, E. & Manyatera, G., 2014. African Disability Rights Yearbook: Zimbabwe. [Online] Available: <http://www.adry.up.ac.za/index.php/2014-2-section-b-country-reports/zimbabwe>

Manjoo, R., 2012. Report of the Special Rapporteur on violence against women, its causes and consequences; UN General Assembly; UN Doc. A/67/227.

Masters. S.H, 2013. "Pharmaceutical stock-out in Uganda, Kenya and Ghana - A thesis submitted in partial fulfillment of the requirements for the degree of Master of Public Health." [Online] Available at:
https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/24274/Masters_was_hington_02500_12163.pdf?sequence=1 . Accessed: 20 June 2017

Matsoha – Makhoali, M., 2015 Disability Lesotho: Advocacy Aspect. A call for the enactment of the Disability Equity Bill by the 9th Parliament of Lesotho. Issue 6 Vol. 2

Mavundla, S.D., 2015. 'Country report: Swaziland' (2015) 3 African Disability Rights Yearbook Pretoria, South Africa. Volume 3 2015: 245-264

McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988). The social ecology of health promotion interventions. *Health Education Quarterly*, 15(4):351-377. Retrieved May 1, 2012, from
http://tamhsc.academia.edu/KennethMcLeroy/Papers/81901/An_Ecological_Perspective_on_Health_Promotion_Programs

Méndez, Juan. E, (2013) Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly; UN.Doc A/HRC/22/53.

Ministry of Health and Social Services, 2001. National Policy for Reproductive Health. [Online] Available: <http://www.youth-policy.com/policies/Namibia%20National%20Policy%20for%20Reproductive%20Health.pdf> [Accessed 27 June 2017].

Ministry of Health, 2000. First Draft: Reproductive health Policy. [Online] Available: <http://www.youth-policy.com/policies/Zambia%20Reproductive%20Health%20Policy.pdf> [Accessed 26 June 2017].

Ministry of Health, 2006. National Reproductive Health Strategy 2006–2015: Ethiopia. [Online] Available: [http://phe-ethiopia.org/admin/uploads/attachment-161-National_RH_strat\[1\].pdf](http://phe-ethiopia.org/admin/uploads/attachment-161-National_RH_strat[1].pdf) [Accessed 27 June 2017].

Mori, A.T. and Ownya, J , 2014. "Stock-outs of antiretroviral drugs and coping strategies used to prevent changes in treatment regimens in Kinondoni District, Tanzania: a cross-sectional study." *Journal of Pharmaceutical Policy and Practice* 7:3

Morris, B. J., Wamai, R. G., Henebeng, E. B., Tobian, A. A., Klausner, J. D., Banerjee, J., & Hankins, C. A. (2016). Estimation of country-specific and global prevalence of male circumcision. *Population Health Metrics*, 14, 4. <http://doi.org/10.1186/s12963-016-0073-5>

Mozlegal, Lda, Constitution of the Republic of Mozambique, 1990. [Online]. Available. [http://confinder.richmond.edu/admin/docs/Constitution_\(in_force_21_01_05\)\(English\)-Mozlegal.pdf](http://confinder.richmond.edu/admin/docs/Constitution_(in_force_21_01_05)(English)-Mozlegal.pdf) [Accessed 27 June 2017].

Mprah, M.K., 2013, 'Knowledge and use of contraceptive methods amongst deaf people in Ghana', *African Journal of Disability* 2(1), Art. #43, 9 pages.
<http://dx.doi.org/10.4102/ajod.v2i1.43>

Munymana, J., M'kumbuzi, V., Mapira, H., Nzabanterura, I., Uwamariya, I. & Shema, E. 2014, "Prevalence of HIV among people with physical disabilities in Rwanda", *Central African Journal of Medicine*, vol. 60, no. 9-12, pp. 62-69.

Murungi, N. et al., 2012 *Regional Developments: Disability Rights in the Sub-regional Economic Communities 2011-2012*

Naicker et al., 2009. "Shortage of Healthcare Workers in Developing Countries", *Africa. Ethnicity & Disease*, Volume 19, Spring 2009

Namibia Statistics Agency, 2016. *Namibia 2011 Census Disability Report*. [Online] Available: http://cms.my.na/assets/documents/Namibia_2011_Disability_Report.pdf

National AIDS Commission, Lesotho, 2006. *National HIV and AIDS Strategic Plan 2006 – 2011*. [Online]. Available: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---portray/-ilo_aids/documents/legaldocument/wcms_126751.pdf [Accessed 27 June 2017].

National AIDS Commission, Lesotho, 2007. *National HIV and AIDS Monitoring and Evaluation Plan (2006-2011)*

National Assembly of Zambia, 2017. "Persons with Disabilities Act". [Online] Available at: <http://www.parliament.gov.zm/node/790>. Accessed: 17 June 2016

National Bureau of Statistics, 2008. "Tanzania Disability Survey Report 2008"

National Council for Population and Development, 2013. *Kenya Adolescent Reproductive Health and Development Policy: Implementation Assessment Report*. [Online] Available: <http://www.prb.org/pdf13/kenya-policy-assessment-report.pdf> [Accessed 27 June 2017].

National Dissemination Center for Children with Disabilities, 2012. "Considering assistive technology. Available online: <http://nichcy.org/schoolage/iep/meetings/special-factors/considering>

National Institute of Health, no date. "How does rehabilitative & assistive technology benefit people with disabilities?". Available online: <https://www.nichd.nih.gov/health/topics/rehabtech/conditioninfo/Pages/help.aspx#top>

NCPWD, 2017. "Disability rights are human rights: Mainstreaming" Available at: http://ncpwd.go.ke/index.php?option=com_content&view=article&id=85&catid=79&Itemid=563. Accessed: 16 June 2017 Available at: <http://macoha.mw/>.

New Zimbabwe, 2017. *Zimbabwe: People Living with Disabilities Call for Repeal of Law*. [Online] Available: <http://allafrica.com/stories/201701040033.html>

New Zimbabwe, 2017. *Zimbabwe: People Living with Disabilities Call for Repeal of Law*. [Online] Available: <http://allafrica.com/stories/201701040033.html>

Novartis, 2013. "Africa struggles to fill its health worker shortage." Available [online]: <https://www.novartis.com/news/africa-struggles-fill-its-health-worker-shortage>

Ntinda, R., 2013. 'Country Report: Namibia': African Disability Rights Yearbook Pretoria, South Africa. Volume 1 2013: 261-275

NWO, 2015. "First projects on Sexual and Reproductive Health and Rights granted". Available online: <https://www.nwo.nl/en/news-and-events/news/2015/wotro/2015.07.10-grants-srhr.html>

O'Connor, J. Literature Review on Provision of Appropriate and Accessible Support to People with an Intellectual Disability who are Experiencing Crisis Pregnancy. Available at: <http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/200FC923F86AE299802577A4003355CF?OpenDocument>

Oladuni, T.M., 2012 Sexual Behavior and Practices Among Adolescents with Disabilities in Southwest Nigeria. *Sex Disabil* (2012) 30:289–299 Springer Science+Business Media, LLC 2012 DOI 10.1007/s11195-012-9270-8

Olajide, F.O., Arije, O.O., Afolabi, O.T. & Omisore, A.G. 2014, "Awareness and use of modern contraceptives among physically challenged in-school adolescents in Osun State, Nigeria: original research article", *African Journal of Reproductive Health*, vol. 18, no. 2, pp. 87-96.

Oyaro, LO., 2014. 'Country Report: Uganda' (2014) 2 African Disability Rights Yearbook 247-266

Panos Institute Southern Africa, 2013. Media Brief on Prevention of Mother-to-Child-Transmission PMTCT of HIV in Lesotho. [Online]. Available: <http://www.panos.org.zm/wp-content/uploads/2014/04/Panos-PMTCT-Lesotho.pdf> [Accessed 27 June 2017].

Papo, JK, Bauni EK, Sanders EJ, Brocklehurst P and Jaffe HW, 2011. "Exploring the condom gap: is supply or demand the limiting factor - condom access and use in an urban and a rural setting in Kilifi district, Kenya". *Aids* 25: 247–255.

Petchesky, R. P. (1995). From population control to reproductive rights: feminist fault lines. *Reproductive Health Matters*, 3(6), 152-162. DOI: 10.1016/0968-8080(95)90172-8.

Programme of Action of the International Conference on Population and Development. ICPD Programme of Action. in International Conference on Population and Development Sept. 5-13, 1994. 1995. Cairo, Egypt: United Nations.

Republic of Kenya, Ministry of Finance and Planning, 2000. National Population Policy for Sustainable Development, No. 1 of 2000. [Online] Available: https://www.afidep.org/?wpfb_dl=83 [Accessed 27 June 2017].

Republic of Kenya, Ministry of Health, 2007. National reproductive health policy: Enhancing reproductive health status for all Kenyans. [Online] Available: https://www.k4health.org/sites/default/files/National%20Reproductive%20Health%20Policy%20booklet_0.pdf [Accessed 27 June 2017].

Republic of Kenya, Ministry of Health, 2015. National Adolescent Sexual and Reproductive Health Policy. [Online] Available: <http://www.maishamaarifa.or.ke/Content/docs/Ministry-of-Health-ASRH-Booklet-Final.pdf> [Accessed 27 June 2017].

Republic of Malawi, Ministry of Youth and Sports, 2013. National Youth Policy 2013. [Online] Available: http://www.youthpolicy.org/national/Malawi_2013_National_Youth_Policy.pdf [Accessed June 27 2017].

Republic of Mauritius, Ministry of Health and Quality of Life, 2007. The National Sexual and Reproductive Health Policy. [Online] Available: <http://health.govmu.org/English/Documents/healthpol07.pdf> [Accessed 27 June 2017].

Republic of Mauritius, Ministry of Youth and Sports, 2016. National Youth Policy 2016. [Online] Available: <http://mys.govmu.org/English/Documents/National%20Youth%20Policy/NYP2016.pdf>

Republic of Namibia, Ministry of Education, 2013. Sector Policy on Inclusive Education. [Online] Available: <https://www.moe.gov.na/files/downloads/MoE%20Sector%20Policy%20on%20Inclusive%20Education.pdf>

Republic of Uganda Ministry of Health, 2001. The National Policy Guidelines and Service Standards for Reproductive Health Services. [Online]. Available: <http://www.youth-policy.com/Policies/Uganda%20National%20Policy%20Guidelines%20and%20Service%20standards%20for%20Reproductive%20Health%20Services.pdf> [Accessed: 27 June 2017].

Republic of Uganda Ministry of Health, 2004 National Adolescent Health Policy for Uganda. [Online]. Available: <http://www.youth-policy.com/Policies/UGAyouthpol2004.pdf> [Accessed:27 June 2017].

Republic of Uganda Ministry of Health, 2010a. The Second National Health Policy Promoting Peoples Health to Enhance Socio-economic development. [Online] Available: <http://apps.who.int/medicinedocs/documents/s18426en/s18426en.pdf> [Accessed: 27 June 2017].

Republic of Uganda Ministry of Health, 2010b. Uganda HIV Counselling and Testing Policy 3rd Edition. [Online]. Available: https://www.k4health.org/sites/default/files/HCT%20Policy_%20Final%202010.pdf [Accessed 27 June 2017]

Republic of Uganda, Ministry of Health, 2004 National Adolescent Health Policy for Uganda. [Online]. Available: <http://www.youth-policy.com/Policies/UGAyouthpol2004.pdf> [Accessed: 27 June 2017].

SADC, 2001. Treaty of the southern African development community. [Online] Accessed: <http://www.chr.up.ac.za/undp/subregional/docs/sadc8.pdf> [Available 27 June 2017]

SADC, 2014. "Towards a common future" [Online] Available at: <https://www.sadc.int/news-events/news/youth-forum> . Accessed 17 June 2017

Save the Children International, 2016

Save the Children International, 2016. Annual Review 2015 [Online] Available: <https://www.savethechildren.net/sites/default/files/libraries/Save%20the%20Children%20Annual%20Review%202015.pdf> [Accessed 26 June 2016].

Save the Children, 2014. "Global Accountability Report 2014" [Online] Available at: <https://www.savethechildren.net/sites/default/files/libraries/stci%20accountability%20report%20final%20031115.pdf>. Accessed: 20 June 2017

Sex Transm Dis. 41(10):583-8. doi: 10.1097/OLQ.000000000000182.

Shale, 2015. 'Country report: Lesotho. African Disability Rights Yearbook 183-202. Pretoria, South Africa. Volume 3 2015

Sida, 2014a. Disability Rights in Ethiopia. [Online] Available: <http://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-ethiopia.pdf> [Accessed 26 June 2017]

SIDA, 2014b. Disability Rights in Mozambique [Online] Available: <http://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-mozambique.pdf> [Accessed 26 June 2017]

SIDA, 2014c. Disability Rights in Zimbabwe. [Online] Available: <http://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-zimbabwe.pdf>

Sida, 2017. Sida administers half of Sweden's development aid budget. [Online] Available: <http://www.sida.se/English/About-us/Budget/> [Accessed 26 June 2016].

Singh, SR., Eghdami. MR. and Singh, S (2014). The Concept of Social Vulnerability: A Review from Disaster Perspectives. International Journal of Interdisciplinary and Multidisciplinary Studies Vol 1, No.6 71-82.

South African Youth Movement, 2014. "SAYM Programs" [Online] Available at: <http://www.saym.co.za/portfolio/>. Accessed 17 June 2017

Swaziland Government (2010). 2007 Population and housing census: Fertility, nuptiality, disability and mortality.

Tanzania Ministry of Health, 2014. "Global AIDS Response Country Progress Report"

TASC ERITREA, 2004. Improving Health Care Delivery Systems in Eritrea, Final Report. [Online]. Available. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=4454&lid=3 [Accessed 27 Jun. 2017].

TesfaNews, 2013. HIV/AIDS in Eritrea: Some Insight on Progress and Continued Challenges. [Online]. Available: <https://www.tesfanews.net/hivaids-in-eritrea-some-insight-on-progress-and-continued-challenges/> [Accessed 27 June 2017].

The Communication Initiative Network, 2017. "Soul City Regional Programme on Sexual and Reproductive Health and Rights". [Online] Available at: <http://www.comminit.com/global/content/soul-city-regional-programme-sexual-and-reproductive-health-and-rights>. Accessed: 18 June 2017

The Constitution of the Democratic Republic of the Congo, 2005

The Global Fund, 2016. The Global Fund 2016 Annual Financial Report. [Online] Available: https://www.theglobalfund.org/media/6388/corporate_2016annualfinancial_report_en.pdf [Accessed 26 June 2017]

The Global Fund, 2017. The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2017. "Government Donors". [Online] Available at: <https://www.theglobalfund.org/en/government/> . Accessed: 20 June 2017

U.S. Department of State. (2011). 2010 Country Reports on Human Rights Practices: Comoros. [online] Available at: <https://www.state.gov/j/drl/rls/hrrpt/2010/af/154339.htm> [Accessed 27 Jun. 2017].

UN Enable, 2006. Seventh Session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 2006. 16 January - 3 February 2006 [Online] Available: <http://www.un.org/esa/socdev/enable/rights/ahcstata2sevschair.htm> [Accessed 17 June 2017].

UN, 1993. "Standard Rules on the Equalization of Opportunities for Persons with Disabilities". New York, United Nations (<http://www.un.org/esa/socdev/enable/dissre00.htm>)

UNAIDS, 2013a. Getting to zero: HIV in Eastern and Southern Africa, 2013 Report on the HIV epidemic in Eastern and Southern Africa

UNAIDS, 2013b. UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework. [Online] Available: http://www.unaids.org/sites/default/files/sub_landing/files/20131405GMAfinal_UBRAF_BUDGET%202014-2015.pdf [Accessed 26 June 2017]

UNAIDS, 2014a. "The Gap Report: People with disabilities" [Online] Available at: http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf. Accessed: 20 June 2017

UNAIDS, 2014b. UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework Snapshots: 30+ High Impact Countries [Online] Available: http://www.unaids.org/sites/default/files/documents/20140627_UNAIDS_Snapshots_EN.pdf [Accessed 26 July 2017]

UNAIDS, WHO OHCHR, 2009. "Disability and HIV Policy Brief" [Online] Available at: http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf. Accessed: 20 June 2017

UNCRPD, 2006. Convention on the Rights of Persons with Disabilities Available online: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-1-purpose.html>

UNDESA, no date. Fact Sheet: Definition of Youth. <http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf> (accessed: 20/06/2017 last updated: unknown)

UNDP, 2016. Funding Compendium 2015. [Online] Available: <http://www.undp.org/content/dam/undp/library/corporate/Partnerships/Funding%20Compendium%202015.pdf> [Accessed 27 July 2017]

UNESCO, 2013. Young People Today, Time to Act Now. "Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa"

UNESCO, 2014. Approved Programme and Budget 2014-2017 37 C/5. [Online]. Available: <http://unesdoc.unesco.org/images/0022/002266/226695e.pdf> [Accessed 26 July 2017].

UNESCO, 2016. "Strengthening sexual and reproductive health and HIV prevention amongst children and young people through promoting comprehensive sexuality education in Eastern and Southern Africa (2013 – 2015); End Term Evaluation Report"

UNFPA, 2012. State of the World Population 2012: By choice, not by chance – family planning, human rights and development. New York: United Nations Population Fund (UNFPA).

UNFPA, 2013. Motherhood in childhood: facing the challenge of adolescent pregnancy

UNFPA, 2014. "Adding it up: The cost and benefit of investing in sexual and reproductive health". <http://www.unfpa.org/sites/default/files/pub-pdf/Adding%20It%20Up-Final-11.18.14.pdf>. Accessed May 2017

UNFPA, 2015 We Decide: Young persons with disabilities. A programme for equal opportunities and a life free of violence.

UNFPA, 2016. Sexual and Reproductive Health- Overview. Available online: <http://www.unfpa.org/sexual-reproductive-health>

UNFPA, 2016c. "UNFPA Consultative Meeting Report, 2016 South Africa"

UNFPA, 2017a. "Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled." [Online] Available: <http://www.unfpa.org/>. Accessed May 2017

UNFPA, 2017b “UNFPA Supplies”. [Online] Available at: <http://www.unfpa.org/unfpa-supplies> Accessed: 20 June 2017

UNFPA, 2017c. Transparency Portal. [Online] Available: <http://www.unfpa.org/transparency-portal> [Accessed: 26 June 2017].

UNFPA and Center for Reproductive Rights, Reproductive Rights: A Tool for Monitoring State Obligations. none, UNFPA: none

UNFPA, no date Sexual and Reproductive Health. <http://www.unfpa.org/sexual-reproductive-health> (Date updated: unknown; Date accessed: 25/06/2017)

UNICEF, 2012. Women with Disabilities: An essential group for MTCT elimination. A note on bottlenecks and priorities for action. Available online: https://www.unicef.org/aids/files/Women-SA_8.5x11_final_web_r1.pdf

UNICEF, 2016. Annual Report 2015. [Online] Available: https://www.unicef.org/publications/files/UNICEF_Annual_Report_2015_En.pdf [Accessed 27 July 2017]

UNICEF, 2017a. “Communication for Development (C4D)”. [Online] Available at: https://www.unicef.org/cbsc/index_42352.html . Accessed: 18 June 2017

UNICEF, 2017b. UNICEF Eastern and Southern Africa Regional Office Annual Report 2016. [Online] Available: https://www.unicef.org/about/annualreport/files/ESARO_AR_2016.pdf [Accessed 27 July 2017]

United Nations Youth, 2017 “Youth Participation” [Online] Available at: <http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-participation.pdf>. Accessed 17 June 2017

University of Pretoria, 2014. Africa Disability Right yearbook. Pretoria, South Africa. Volume 2 2014

University of Pretoria, 2015. Africa Disability Right yearbook. Pretoria, South Africa. Volume 3 2015

University of Pretoria. 2014 “African Disability Rights Yearbook” [Online] Available at: <http://www.adry.up.ac.za/>. Accessed: 16 June 2017

UNPRPD, 2017. Consolidated Annual Financial Report of the Administrative Agent for the UNPRPD Disability Fund. [Online] Available: <http://mptf.undp.org/factsheet/fund/RPD00> [Accessed 27 July 2017]

USAID, 2000. Eritrea Final Country Report, January 2000. [Online]. Available. http://pdf.usaid.gov/pdf_docs/Pnach156.pdf [Accessed 27 Jun. 2017].

USAID, 2015. Youth-Friendly Health Services in Malawi: Young People’s Sexual Experiences. [Online] Available:

https://www.healthpolicyproject.com/pubs/750_MalawiYouthExperiencesBriefA.pdf
[Accessed June 27 2017].

USAID, 2017. [Online] Available: USAID FY 2016 Agency Financial Report.
https://www.usaid.gov/sites/default/files/documents/1868/USAIDFY2016_AFR_508.pdf
[Accessed 26 July 2017]

WHO, 2007. "Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action".

WHO, 2011. "World report on disability". Geneva, World Health Organization.

WHO, 2012a. "From Evidence to Policy: Expanding access to family planning – Expanding access to contraceptive services for adolescents". Geneva: World Health Organization.

WHO, 2012b. Fact Sheet: Voluntary Medical Male Circumcision for HIV prevention.
http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/

WHO, 2017. "Health and Environment Linkages Initiatives" [Online] Available:
http://www.who.int/heli/tools/legis_regul/en/ Accessed: May 2017

WHO, no date. "International classification of functioning, disability and health (ICF)".
<http://www.who.int/classifications/icf/en/> (accessed: 14/03/2017 last updated: 27/01/2017)

WHO, no date. CCF Case Studies, Eritrea: From Planning to Implementation. [Online]. Available:
http://www.who.int/workforcealliance/knowledge/resources/CCF_CaseStudy_Eritrea.pdf?ua=1 [Accessed 27 Jun. 2017].

WHO, UNAIDS, UNICEF, 2010. "Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector". Geneva: WHO; 2010.

WHO. 2015. Cervical Cancer amongst women in Africa. <http://www.afro.who.int/en/media-centre/afro-feature/item/7557-cervical-cancer-common-amongst-african-women.html>

WHO, 2017. Consolidated guideline on sexual and reproductive health and rights of women living with HIV.

World Bank, 2017. Annual Report 2016. [Online] Available:
<http://www.worldbank.org/en/about/annual-report/regions> [Accessed 27 July 2017]

Wright, J., 2015. Health Finance & Governance Project: Essential Package of Health Services Country Snapshot: Uganda.[Online] Available: <http://www.poline.org/node/644385> [accessed 27 June 2017].

WWDA, Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA), 2011. Sterilization of Women and Girls with Disabilities: A Briefing Paper. Available at:
http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf.

Yibeltal, K., 2013. Law and Policy Situation of Persons with Disabilities in Ethiopia.[Online] Available: https://www.dppc.gov.et/downloadable/reports/Early_warning/DRR%20DAY-2013/FENAPD%20Law%20and%20policy%20situation%20of%20persons%20with%20disabilities_Kassahun%20yibeltal.pdf [Accessed 27 June 2017].

Young People Today: Time to Act Now, no date. Malawi. [Online] Available: <http://youngpeopletoday.net/country/malawi/> [Accessed 27 June 2017]

Zambia Persons with Disabilities Act [No.6 of 2012].

© 2017 KPMG Services Proprietary Limited, a South African company and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in South Africa. KPMG and the KPMG logo are registered trademarks of KPMG International Cooperative (“KPMG International”), a Swiss entity.

The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

The KPMG name and logo are registered trademarks or trademarks of KPMG International. 16992MC