

## RE-EXAMINING ACCESS TO REPRODUCTIVE HEALTH SERVICES FOR WOMEN AND GIRLS LIVING WITH DISABILITIES IN NIGERIA

By

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### Abstract

*Access to sexual and reproductive health services (SRHS) for women and girls with disabilities (WGWD) has been receiving global attention. WGWD possess similar sexual needs as their counterparts without disabilities. WGWD encounter compounded stereotypes and systemic barriers to accessing SRHS. There is no specific legislation addressing access to SRHS in Nigeria. Moreover, for international instruments containing such provisions, domestication within Nigeria's legal framework remains a challenge. Furthermore, there is the problem of implementation of existing provisions. The authors examine the right of access of WGWD to SRHS in Nigeria and the various SRHS available to WGWD, exploring the barriers they face in accessing quality services and the legal framework available for their protection and SRHS in Nigeria. The authors conclude that access to SRHS for WGWD in Nigeria remains limited. Despite being a substantial portion of the population, they encounter barriers to accessing adequate SRHS. The authors recommend that efforts to address the disparities in access to SRHS for WGWD require collaborative action from all stakeholders, enactment and enforcement of legislation tailored to the particular needs of WGWD and structural changes, such as communication and ensuring compliance with accessibility standards.*

**Keywords:** Health service providers, Sexual and reproductive health rights, Sexual and reproductive health services, Women and girls with disabilities

### 1.0 Introduction

Access to reproductive health services is important for all women. Health for women is more than reproductive health. Women have specific health needs related to their sexual and reproductive function, collectively expressed in the reproductive health package.

Women have an elaborate reproductive system that is vulnerable to dysfunction or disease, even before it functions or after it ceases to function.<sup>1</sup> For this reason, much global attention has been drawn to women. The United Nations Women (UN Women) states that “Reproductive rights are integral to women's rights, a fact that is upheld by international agreements and reflected in law in different parts of the world”.<sup>2</sup> However, women continue to face constant violation and discrimination in the exercise and enjoyment of these rights.<sup>3</sup>

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<sup>1</sup> Rebecca. J. Cook, ‘Reproductive Health and Human Rights’ (Oxford University Press 2003)

<sup>2</sup> UN Women, ‘Statement; Reproductive rights are women's rights and human rights’ 2022 <<https://www.unwomen.org/en/news-stories/statement/2022/06/statement-reproductive-rights-are-womens-rights-and-human-rights>> accessed 19 August, 2024

<sup>3</sup> Hacey ‘Sexual reproductive health and right of women and girls in Nigeria’ 2020 <<https://hacey.org/advocacy/sexual-health-reproductive-women-girls>> accessed 19 August 2024

Women and girls, despite constituting a significant portion of the population, are often perceived as minorities within societal structures. More disturbing is that, within this overarching category, certain subsets of women face even greater vulnerabilities and marginalisation. These women including internally displaced persons, refugees, young girls in rural areas, particularly, women and girls living with disabilities in Nigeria,<sup>4</sup> experience intersecting forms of discrimination and neglect in accessing reproductive health services. Approximately 25 million Nigerians live with one form of disability or the other with an estimated 13 million of this population being women and girls.<sup>5</sup>

This article examines the right of access of women and girls with disabilities (WGWD) to sexual and reproductive health services (SRHS) in Nigeria, the barriers they face in accessing quality services and the legal framework available for their protection and to access SRHS in Nigeria.

To effectively engage this discourse, it is necessary to raise these pertinent questions:

- What are reproductive rights and access to reproductive and sexual health services?
- What are the sexual and reproductive rights of women and girls with disabilities in Nigeria and in what forms are these rights violated?
- Do women and girls living with disabilities in Nigeria have access to quality sexual and reproductive health services?
- What are the legal and institutional mechanisms to ensure access to sexual and reproductive health services for women and girls living with disabilities and how effective are these legal instruments and mechanisms?
- What are the factors or barriers impeding access to sexual and reproductive health rights of women and girls with disabilities in Nigeria?
- What can be done to better protect the reproductive and sexual health rights of women and girls living with disabilities in Nigeria?

## 2.0 Reproductive Rights, Sexual Health Services and Access

The World Health Organisation in 1987 defined the term reproductive health. The WHO Constitution defined health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.<sup>6</sup> Reproductive health, in the context of this positive definition, would therefore have some expectations. It would mean that people can reproduce, to regulate their fertility, that women can go safely through pregnancy and childbirth, that reproduction is carried to a successful outcome through infant and child survival and well-being and that people can enjoy and have safe sex”.<sup>7</sup>

<sup>4</sup> Enable Me. ‘5 Sexual and reproductive health barriers for persons with disabilities’ <<https://www.enableme.ke/en/article/5-sexual-and-reproductive-health-barriers-for-persons-with-disabilities-8522>> accessed 19 August 2024

<sup>5</sup> Vanguard ‘Policy on sexual reproductive health paramount to enhancing lives of PWDS- FG’ Vanguard 23 April 2019 <[www.vanguardngr.com/2019/04/policy-on-sexual-reproductive-healthparamount-to-enhancing-lives-of-pwds-fg/amp/](http://www.vanguardngr.com/2019/04/policy-on-sexual-reproductive-healthparamount-to-enhancing-lives-of-pwds-fg/amp/)> accessed 19 August 2024

<sup>6</sup> Norman Satorius ‘The Meanings of Health and its Promotion’ *Croatian Medical Journal* [2006] 47(4) <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080455/>> accessed 20 August 2024

<sup>7</sup> MF Fathalla ‘Promotion of research in human reproduction: global needs and perspectives’ *Hum Reprod.* [1988] Jan, 3(1) <<https://pubmed.ncbi.nlm.nih.gov/3350938/>> - reproductive health care is described as the collection of strategies, techniques,

Health is a state of total well-being in every area. This makes sexual and reproductive health a vital aspect of human life. Reproductive health is not just a major health issue, it is also a development issue and a human rights issue. Due to reasons of impact, urgency, and inequity, reproductive health is a global concern.<sup>8</sup> Good sexual and reproductive health is defined as complete physical, mental and social well-being in all aspects of the reproductive system.<sup>9</sup> It emphasises that people should not only have a satisfying and safe sex life but also possess the ability to reproduce and choose whether, when and how frequently to do so.

To maintain sexual and reproductive health, people must have access to correct information as well as the safe, effective, inexpensive and acceptable contraception method of their choice. They must be educated and empowered to protect themselves against sexually transmitted diseases. Also, when women decide to have children, they must have access to qualified healthcare experts and resources to ensure a good pregnancy, safe birth and healthy child.<sup>10</sup> Every person has the right to make their own decisions regarding their sexual and reproductive health.

The concept of reproductive health received great attention in the UN ICPD held in Cairo in 1994. It adopted the Programme of action and embraced recognition of rights as a better alternative to narrowly focused family planning programmes in a bid to control population growth. The first international adoption of a definition of reproductive health was also recorded in the conference.<sup>11</sup> It was at this conference that sexual rights were recognised as human rights.<sup>12</sup> It was a deviation from the usual way of telling women what to do with their bodies. Reproductive health care is described as the collection of strategies, techniques, and services that promote reproductive health and well-being by preventing and resolving reproductive health issues. It also covers sexual health, the objective of which is the advancement of life and personal relationships, rather than just preventing and caring for reproduction and sexually transmitted diseases.

According to the World Congress on Sexology<sup>13</sup> definition of sexual health should include the following components; the ability to enjoy mutually fulfilling sexual relationships, freedom from sexual abuse, coercion, or harassment, safety from sexually transmitted diseases, and success in achieving or preventing pregnancy. Individuals, couples, families, and communities all benefit greatly from good sexual health. A healthy and respectful approach to sexuality, assuring optimistic and safe experiences devoid of compulsion and violence is important. Access to comprehensive knowledge and information, and services that promote reproductive health and well-being by preventing and resolving reproductive health issues. It also covers sexual health, the objective of which is the advancement of life and personal relationships, rather than just selling and caring for reproduction and sexually transmitted diseases.

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<sup>8</sup> Rebecca J. (n.1)

<sup>9</sup> UNFPA 'Sexual & Reproductive Health' <<https://esaro.unfpa.org/en/topics/sexual-reproductivehealth#>> accessed 19 August 2024

<sup>10</sup> Ibid.

<sup>11</sup> Rebecca J. (n.1)

<sup>12</sup> Yinka Olomojobi, 'Human Rights on Gender, Sex and the Law in Nigeria' (Princeton Publishing Company 2013)

<sup>13</sup> M Schaaf 'Negotiating Sexuality in the Convention on the Rights of Persons with Disabilities' 2011 <https://sur.conectas.org/en/negotiating-sexuality-convention-rights-persons-disabilities/>.

risk awareness, the ability to get sexual health treatment, and living in an environment that promotes sexual health are all necessary for achieving sexual health.<sup>14</sup>

### 3.0 Women and Girls with Disabilities Reproductive and Sexual Rights

During the General Assembly in 2018, several issues regarding the sexual rights of persons living with disabilities were analysed.<sup>15</sup> The importance of incorporating the rights and requirements of people with disabilities into healthcare services was emphasised. This entails removing obstacles that hinder their access to healthcare and implementing specialised services and programs tailored to their unique needs. In comparison to the general population, individuals with disabilities face elevated risks of accidents, violence, and chronic diseases. Nonetheless, they have the potential to lead healthy, productive, active, and long lives. Disparities in their ability to enjoy a healthy life are primarily attributed to the lack of action by governments, societal stigma, discrimination, limited healthcare knowledge, poverty, and social exclusion.<sup>16</sup>

Many women are handicapped- discriminated against merely because they are women. Having a disability compounds this prejudice, particularly for women in developing countries such as Nigeria, where the majority of the millions of disabled women can be found. For them, disability diminishes sharply their often-inferior role, even in their households. The stigma of disability, with its myths and fears, increases their social isolation. When no rehabilitation facilities are available, they become immobile and housebound and their isolation is complete. Women with disabilities suffer not only the usual discrimination against females but are further discriminated against because of their disabilities. This double prejudice is the main cause of the inferior status of women with disabilities, making them the world's most disadvantaged group.<sup>17</sup> It is the cause of hostility and negative attitudes that are often more debilitating for disabled women than the disability itself.

The Convention on the Rights of Persons with Disabilities established international law, mandating that all governments ensure access to sexual and reproductive health services for individuals with disabilities<sup>18</sup>. However, in practice, women with disabilities encounter difficulties accessing these services due to several reasons such as being treated like children, being wrongly perceived as asexual or hypersexual, as being incapable of reproduction, facing stereotypes suggesting they are unattractive, unfit for marriage, or unsuitable as sexual partners.<sup>19</sup> These misconceptions are far from reality but cause significant barriers preventing them from receiving sexual and reproductive health services and

<sup>14</sup> WHO 'Sexual Health' <[https://www.who.int/health-topics/sexualhealth#tab=tab\\_1](https://www.who.int/health-topics/sexualhealth#tab=tab_1)> accessed 19 August 2024

<sup>15</sup> UN 'Women, Girls with Disabilities Denied Sexual Health Rights, Third Committee Expert Stresses as Others Call for Protection of Journalists, Freedom to Worship' <<https://press.un.org/en/2018/gashc4240.doc.htm>> accessed 19 August 2024

<sup>16</sup> C Shalev 'Rights to sexual and reproductive health; the ICPD and the Convention on Elimination of all forms of discrimination' 1998 <<https://www.un.org/womenwatch/daw/csw/shalev.html>> accessed 19 August 2024

<sup>17</sup> E Boylan 'Women and Disability' (The Bath Press 1991)

<sup>18</sup> Article 25 Convention on The Rights of Persons with Disabilities

<sup>19</sup> United Nations Office of the High Commissioner of Human Rights 'Submission to the Special Rapporteur on Rights of Persons with Disabilities on Right of Persons with Disabilities to the Highest Attainable Standard of Health Sexual RightsInitiative' <<https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/StandardHealth/SexualRightsInitiative.docx>> accessed 19 August 2024

susceptible to sexual violence and abuse within our societies.<sup>20</sup> It is, therefore, required that there are procedures put in place to ensure that they are seen, heard, respected and protected as far as their sexual and reproductive health rights are concerned. Women and girls living with disabilities should have access to age-appropriate information on their sexual health and should be given awareness and freedom to enjoy their sexual and reproductive health rights.<sup>21</sup>

The CPRD adopted in 2006 emphasises a paradigm shift, placing responsibility on state parties rather than individuals with disabilities for promoting and protecting rights, including reproductive rights. Progress has been made but challenges persist, such as higher risks of physical and sexual abuse among individuals with disabilities. The UNFPA and WHO<sup>22</sup> have outlined ten key messages to raise awareness about disability rights, emphasising the importance of inclusion and participation of individuals with disabilities in all programs and decision-making processes. They emphasise that disability affects everyone and that having a disability does not imply being unwell. PWDs are entitled to sexual experiences, and accessibility should encompass more than just physical structures. Their aspirations are no different from those of others, but prejudice remains a significant barrier. They have the right to self-determination, privacy, and respect and integrating health services for them is both beneficial and feasible. Their active involvement in program design is important, reflecting the principle of *“Nothing about us without us”*.<sup>23</sup>

#### **4.0 Access to Quality Sexual and Reproductive Health Services for Women and Girls with Disabilities in Nigeria**

SRHRs include access to SRHS and this right is for all individuals including women and girls with disabilities. All women are entitled to the right to be informed, have access to safe, effective, affordable and acceptable methods of family planning, access to appropriate healthcare services to enable a woman to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy baby.<sup>24</sup> These services are to be available to all women without any form of discrimination.

##### **4.1 Contraceptive Information, Goods and Services**

Access to contraceptive information and services is critical to the health and human rights of WGWDs. It is also linked to other SRHRs as it allows people to attain their desired number of children, if any and to determine the spacing of their pregnancies. Preventing unplanned pregnancies helps to reduce maternal illness and pregnancy-related deaths. This can also help the education of girls and provide opportunities for women to participate in society, including professional employment. Access to contraceptive use is essential for women and girls with disabilities because they often face discrimination in accessing these services. Use of contraceptives is generally low among reproductive-

<sup>20</sup> WHO ‘Guidance notes on promoting sexual and reproductive health for persons with disabilities’ 2009  
<<https://www.who.int/publications/i/item/9789241598682>> accessed 19 August 2024

<sup>21</sup> FIGO ‘#Embrace Equity; Women’s Access to Sexual and Reproductive Health and Rights in Humanitarian Settings’ 2023  
<<https://www.figo.org/news/embraceequity-womens-access-sexual-and-paramount-to-enhancing-lives-of-pwds-fg/amp/>>

<sup>22</sup> WHO (n.20)

<sup>23</sup> WHO (n.20)

<sup>24</sup> UNFPA ‘Reproductive Rights are Human Rights; A Handbook for National Human Rights Institutions’ 2014  
<<https://www.unfpa.org/publications/reproductive-rights-are-human-rights>> accessed 19 August 2024



age females with disabilities. This is influenced by factors such as transportation accessibility, contraceptive awareness, age, type of disability, marital status, knowledge and attitude towards family planning methods, accessibility of nearby health facilities providing family planning services, confidentiality and privacy in healthcare settings, self-perception, and educational and economic status. To increase contraceptive use, specific initiatives must be developed to deliver contraceptive education, information, and services directly to their homes.<sup>25</sup>

The choice of contraceptive option must be exercised freely by the woman without coercion and any form of forced contraception or forced sterilisation is a gross violation of sexual and reproductive health rights and violates various international human rights treaties that expressly preserve the right to be free from torture or cruel, inhuman or degrading treatment or punishment.<sup>26</sup>

#### 4.2 Maternal and New-born Health Services

WGWDs have the right to access maternal and newborn health services. They have the right to benefit from these services equally without discrimination from anybody. To ensure improved and quality maternal service delivery for women with disabilities, there should be the integration of disability into existing skilled birth attendant training curricula.<sup>27</sup> This is important because many service providers lack a comprehensive understanding of disability types and a rights-based approach despite acknowledging the equal right to health for women with disabilities.<sup>28</sup>

These services must be guaranteed as WGWDs have largely been ignored in reproductive health research. They are often thought not to be sexually active and less likely to marry and talk more about having children.<sup>29</sup> WGWDs often face substandard care, discrimination, and abusive treatment in healthcare settings, including during childbirth. Stereotypes about their sexuality and capabilities lead to unacceptable treatment and may prevent them from seeking necessary services, increasing the risk of life-threatening conditions. States must address these issues to ensure the rights and well-being of women with disabilities in maternal health care.<sup>30</sup>

#### 4.3 Comprehensive Sexual Education (CSE)

For WGWDs, the lack of access to sexual education stems from the myth that they do not have sexuality at all. Therefore, sexual and reproductive health interventions for disabled people in Nigeria usually

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<sup>25</sup> Z Tenaw 'Contraceptive use among reproductive-age females with disabilities in central Sidama National Regional State, Ethiopia: a multilevel analysis' *Peer J.* 11 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10184657/>> accessed 19 August 2024

<sup>26</sup> Article 2 United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. See also Article 5 Universal Declaration of Human Rights, Article 5 of the African Charter on Human and Peoples' Rights, Articles 7 and 10 of the International Covenant on Civil and Political Rights.

<sup>27</sup> Joanna Morrison and others 'Disabled women's maternal and newborn health care in rural Nepal: A qualitative study' *National Library of Medicine* (2014) 30(11) <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4217148/>> accessed 19 August 2024

<sup>28</sup> L Ledger 'Access to maternal and newborn health services for women with disabilities in Timor-Leste' 2016 <<https://www.did4all.com.au/Resources/2016%20CBM%20Access%20of%20women%20with%20disabilities%20to%20MNH%20Timor-Leste.pdf>> accessed 19 August 2024

<sup>29</sup> FIGO (n.21)

<sup>30</sup> Enable Me (n.4)

exclude desires and pleasures and only address vulnerabilities to sexual violence or ill health.<sup>31</sup> Research by Okotie and Jolly revealed this in sharing the experience of Jumai who told her cousin she wanted to get intimate with a man and was told that a blind woman should not think about things like that but should be on her knees praying.<sup>32</sup> Women and girls must have access to comprehensive sexual education as this will equip them to understand their bodies and the various stages of sexual development expected.

Individuals with disabilities face significant barriers in accessing comprehensive sexuality education. Physical barriers, lack of accessible materials and exclusion from formal education programs are among the challenges. Existing sexuality education often fails to address the specific needs and issues faced by persons with disabilities. Comprehensive sexual education requires efforts from governments, organisations, and society to ensure accessibility, inclusion, and empowerment for all individuals, regardless of disability.<sup>33</sup> For girls with disabilities, it requires a considerable step for parents to accept that sex education plays a vital part in development and partake in this.<sup>34</sup>

#### **4.4 Information, Testing and Treatment Services for STIs including HIV/AIDS**

Access to information, testing and treatment services for STIs is important for women and girls living with disabilities. Access to affordable and appropriate assistive services is essential for individuals living with HIV and experiencing disabilities.<sup>35</sup> It is important because people with disabilities, particularly women and girls, face stigma and discrimination when seeking sexual and reproductive health and HIV services. They are often excluded from violence prevention efforts despite being at higher risk of experiencing sexual violence. Physical inaccessibility of health and education services, along with attitudinal barriers, further hinder their access to HIV prevention and care. Lack of comprehensive sexuality education leaves young people with disabilities uninformed about HIV and sexuality. Existing HIV-related policies and programs often fail to address the needs of people with disabilities, perpetuating their exclusion from essential services.<sup>36</sup> Healthcare workers play a critical role in providing access to HIV and sexual and reproductive health services and should receive training on the intersection of disability and HIV to ensure inclusive and effective care. Healthcare systems need to evolve to provide integrated and comprehensive care that addresses the needs of people living with HIV, including disability and rehabilitation services.<sup>37</sup> Women with disabilities living with HIV are particularly vulnerable to forced sterilisation and abortion. Communication barriers and socioeconomic factors further impede their access to STI services.

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<sup>31</sup> K Yusuf 'Special Report: How Women with Disabilities Suffer Sexual Abuse from Caregivers' Premium Times 19 November 2019 <<https://www.premiumtimesng.com/health/health-features/496035-special-report-how-women-with-disabilities-suffer-sexual-abuse-from-caregivers.html>> accessed 19 August 2024

<sup>32</sup> Ibid.

<sup>33</sup> Center for Reproductive Rights 'Inclusive Comprehensive Sexuality Education and the CRPD: Submission to the CRPD Committee's Half Day of General Discussion on the Right to Education' <[https://www.ohchr.org/Documents/HRBodies/CRPD/DGD/2015/IDA\\_CRR.doc](https://www.ohchr.org/Documents/HRBodies/CRPD/DGD/2015/IDA_CRR.doc)> accessed 19 August 2024

<sup>34</sup> Shalev (n.16)

<sup>35</sup> UNAID 'Disability and HIV' 2017 <[https://www.unaids.org/sites/default/files/media\\_asset/JC2905\\_disability-and-HIV\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf)> accessed 19 August 2024

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

## 5.0 Barriers and enablers of Access to Sexual and Reproductive Health Services of Women and Girls with Disabilities in Nigeria

Women and girls with disabilities often encounter problems while trying to access sexual and reproductive health services. People with disabilities encounter specific challenges when accessing sexual and reproductive services including discriminatory attitudes towards their sexuality. Society often views people with disabilities as either entirely asexual or hypersexual, perpetuating harmful stereotypes. The view that people with disabilities cannot consent to sexual activity further restricts their sexual expression, making them rely on guardians which strip individuals of their rights and can also impede access. Religious refusal laws may prevent people with disabilities from receiving reproductive health services. These barriers contribute to increased vulnerability to sexual assault, as people with disabilities are disproportionately affected by sexual violence.<sup>38</sup>

Research conducted in Sub-Saharan Africa identified five levels of barriers, encompassing a total of 33 specific obstacles, including national, healthcare system, individual, community, and economic barriers. Many of these barriers are consistent across studies, clinical settings, and geographic locations, which were the same as findings from research in other regions and on general healthcare services. Examples include lack of education on sexual and reproductive health, mistreatment by healthcare workers, and inaccessible facilities.<sup>39</sup> Barriers faced by women and girls with disabilities are made worse by societal norms regarding gender roles, sexuality, extramarital sex, and contraceptive use within and outside of marriage. These are caused by restrictive social and gender norms regarding expectations for women's behaviour.<sup>40</sup> Social marginalisation compounds the challenges, particularly for women with disabilities, who face physical, social, and attitudinal barriers in accessing community resources, including SRH services. These multifaceted barriers underscore the urgent need for targeted interventions and policy reforms to ensure equitable access to SRH services and reproductive rights for individuals with disabilities.<sup>41</sup>

Other factors can worsen these barriers apart from gender. For instance, research conducted in Papua New Guinea<sup>42</sup> to examine the allocation and expenditure of public funds revealed several challenges hindering the delivery and accessibility of healthcare services. These challenges included a shortage of healthcare providers, delays or lack of funding, including payments to healthcare providers, and limited availability of drugs. Consequently, accessing sexual and reproductive health (SRH) services is particularly difficult for certain populations, notably those residing in rural and remote areas, as well as

<sup>38</sup> UNFPA (n.24)

<sup>39</sup> John Kumuori Ganle and others 'Barriers facing Persons with Disability in Accessing Sexual and Reproductive Health Services in Sub-Saharan Africa; A Systematic Review' *PLoS One* [2020] 12(15) <<https://www.ncbi.nlm.nih.gov/PMC7549766>> accessed 20 August 2024

<sup>40</sup> E Burke and others 'A Qualitative Study to explore the Barriers and Enablers for Young People with Disabilities to access Sexual and Reproductive Health Services in Senegal' *Reproductive Health Matters* 2017 25(50) <<https://doi.org/10.1080/09688080.2017.1329607>> accessed 20 August 2024

<sup>41</sup> B Rade and others 'Prevalence and Factors associated with Sexual and Reproductive Health Services use among Reproductive Age Women with Disabilities; a community based Cross-sectional Study' *BMC Women's Health* 2023 23(215) <<https://doi.org/10.1186/s12905-023-02373-5>> accessed 20 August 2024

<sup>42</sup> M Balgry, and others. 'Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island Countries and Territories: A scoping review' 2023 *PLoS ONE* 18(1) <<https://doi.org/10.1371/journal.pone.0280667>> accessed 20 August 2024



groups with specific needs such as young people, persons with disabilities, individuals living with HIV, and those identified as lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI).<sup>43</sup>

Beyond gender-specific barriers, there are also disability-specific barriers, particularly concerning difficulties accessing services. Challenges are faced by those with physical disabilities, such as mobility issues in health facilities and limitations in effective communication with healthcare workers for individuals with hearing impairments. Furthermore, the reliance on others to be accompanied to access health services limits the ability of young people with disabilities to access services confidentially and anonymously. These caregivers can play a role in facilitating access but young people with disabilities often find it difficult to discuss issues related to sexuality due to societal taboos or fear.<sup>44</sup> Communication barriers add another layer of difficulty, especially for individuals with hearing impairments, who struggle to access pregnancy-related care services due to inconsistent communication access and a lack of health information.<sup>45</sup>

The enablers include training healthcare providers in communication and disability sensitivity, ensuring physical accessibility of facilities, and addressing community misconceptions about disability and sexuality through public education initiatives. In a study among the Ashanti and Brong Ahafo Regions of Ghana,<sup>46</sup> the enablers which facilitated access to SRH services and care were the support provided by caregivers and friendly relationships with health providers.<sup>47</sup> In a study in Nepal<sup>48</sup>, a few facilitators were identified such as PWDs were empowered enough to choose their partner, supportive family members, and instances of good treatment by health care providers.<sup>49</sup>

## **6.0 Forms of Infringement of Right to Access of Sexual and Reproductive Services against Girls and Women Living with Disabilities**

A common stereotype in Nigeria is the belief that individuals with disabilities, especially women with disabilities, are not sexually active. However, data from a 2013 survey on HIV and disability in Nigeria contradicts this notion. The survey revealed that 71% of respondents admitted to having had sexual experiences. Interestingly, a higher proportion of adolescents with disabilities (40%) reported having had sex before the age of 15 compared to the general population (16% for women and 3% for men).

### **6.1 Abuse of Physical, Communication and Information Access**

Women and girls with disabilities also face a lack of information and limited mobility barriers while trying to access sexual and reproductive health services.<sup>50</sup> *Article 9 of the CRPD* mandates the accessibility of persons with disabilities to medical facilities and information. Many health centres are

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<sup>43</sup> Balgry (n.42)

<sup>44</sup> Ibid.

<sup>45</sup> UN Department of Economic and Social Affairs '5 Things you should know about Persons with Disabilities' <<https://www.un.org/en/desa/things-you-should-know-about-persons-disabilities>> accessed 20 August 2024

<sup>46</sup> E Badu and others 'Enablers and Barriers in Accessing Sexual and Reproductive Health Services among visually impaired Women in the Ashanti and Brong Ahafo Regions of Ghana's *Reproductive Health Matters* (2018) 26(54) <<https://www.tandfonline.com/doi/word/10.1080/09688080.2018.1537749?needAccess=true>> accessed 20 August 2024

<sup>47</sup> Ibid.

<sup>48</sup> S Bhattarai and others 'Barriers and facilitators to sexual and reproductive health rights for Persons with Disability in Nepal: a scoping review' 2023 <<https://doi.org/10.1101/2023.04.19.23288803>> accessed 20 August 2024

<sup>49</sup> Bhattarai (n.48)

<sup>50</sup> Morrison (n.27)

not designed with persons with disabilities in mind hence the physical inaccessibility and in instances where they are accessible, women with disabilities do not sometimes have the financial means to afford treatments and are also affected by social, psychological and cultural barriers.<sup>51</sup> The barriers include a lack of ramps, adapted examination tables, proximity to the clinic, and mobility within the clinic amongst other concerns. Also, women with disabilities experience a lack of information and communication materials in that they are not in an accessible format, lack of sign language interpreters, lack of braille, etc. Knowledge of sexual and reproductive health rights is limited to women with disabilities as they are stereotypically perceived to not require such information about it.

## 6.2 Denial of Personal Autonomy and Legal Capacity

Women, particularly those with disabilities, face abuse in making independent decisions about their reproductive and sexual health. They often face violence, abuse, and coercive procedures such as forced sterilisation, abortion, and contraception. Gender and disability stereotypes contribute to deliberate prejudice against them, especially when they seek sexual and reproductive health care. Misconceptions about disability and sexuality cause stigma and disempowerment, lowering self-esteem and preventing social inclusion. Legal limitations, parental consent requirements and misconceptions about their capacity all hinder their access to services and decision-making independence. This loss of control over their own lives is equivalent to violence, putting them at risk of negative outcomes such as early marriage.<sup>52</sup>

The CRPD promotes the reproductive autonomy of women and girls with disabilities, ensuring they have equal rights to make decisions about their reproductive health as those without disabilities. The Convention affirms the right of individuals with disabilities to make their own choices, regardless of any disabilities and stresses that lacking decision-making abilities does not justify denying someone with cognitive or intellectual disabilities legal capacity.<sup>53</sup>

There are still grounds to be covered concerning respect for their body autonomy in Nigeria. During the commemoration of the 2022 International Day of Persons with Disabilities, it was stated that perceptions about women and girls with disabilities must be altered, enabling them to make decisions about their bodies and live free from violence. This entails challenging harmful social and gender norms and removing every obstacle to these rights, prioritising the most marginalised individuals who face severe violence and discrimination.<sup>54</sup>

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<sup>51</sup> Carolyn Frohmader and Stephanie Ortoleva 'The Sexual and Reproductive Rights of Women and Girls with Disabilities' *ICPD Beyond 2014 International Conference on Population and Development* <<https://ssrn.com/abstract=2444170>> accessed 20 Aug 2024

<sup>52</sup> OHCHR 'Sexual and reproductive health and rights of girls and young women with disabilities' 2017 <[https://www.ohchr.org/Documents/Issues/Disability/A\\_72\\_133\\_EN.docx](https://www.ohchr.org/Documents/Issues/Disability/A_72_133_EN.docx)> accessed 20 August 2024

<sup>53</sup> K Lee and others 'Sexual and Reproductive Health Services for Women with Disability; A Qualitative Study with Service Providers in the Philippines' *BMC Women's Health* (2015) 15:3 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4606556/>> accessed 19 August 2024

<sup>54</sup> Kazeem Biriowo '64 percent of Women with Disabilities at Risk of Sexual Abuse in Nigeria — Report' *Tribune Online* 3 December 2022 <<https://tribuneonline.ng.com/64-percent-of-women-with-disabilities-at-risk-of-sexual-abuse-in-nigeria-%E2%80%95-report/>> accessed 19 August 2024

### 6.3 Informed Consent and Confidentiality of Information

Informed consent is crucial in healthcare, ensuring clients have the right to choose, refuse, or withdraw from treatment based on full knowledge of the procedure. However, women and girls with disabilities face infringement in accessing SRH information and care due to stigma, lack of awareness and lack of communication. Many healthcare workers lack training in providing care to persons with disabilities, leading to violations of SRH rights, including inappropriate examinations, forced contraception, coerced sterilisation, and obstetric violence.<sup>55</sup>

The CRPD recognises the right of people with disabilities to informed consent in healthcare. Article 12 emphasizes equality before the law and legal capacity, while Article 25 ensures equal access to health services, including SRH, with the requirement of free informed consent. Informed consent involves more than obtaining a signature and requires effective communication to ensure the rights of people with disabilities are respected. Decision-making capacity is fundamental, with all adults presumed to have legal capacity, including those with intellectual disabilities who may require supported decision-making. Healthcare providers need to prepare, communicate effectively, ensure privacy and confidentiality, check understanding, facilitate decision-making support, and act according to the client's will and preference during the informed consent process.<sup>56</sup>

A study conducted in 2013 in Ibadan, Nigeria, revealed that girls with hearing impairments face numerous barriers in accessing reproductive health care services. Communication difficulties and a lack of professional interpreters hinder their access to health services in various ways. For example, they often miss appointments because they cannot hear when their names are called in waiting rooms, leading to feelings of embarrassment and frustration. They also have to rely on family or friends to communicate with health service providers, which compromises patient confidentiality and may result in inaccurate information being conveyed.<sup>57</sup> Lack of confidentiality dissuades women and girls living with disabilities from accessing sexual and reproductive health services. “You see that is why we don’t want to seek reproductive health care or any other help... there is no confidentiality because we have disability.”<sup>58</sup>

#### 6.3.1 Abuse of Right to Marriage, Stigmatised Maternal Services and Denial of Parental Rights

There are stereotypes around motherhood and disabilities. The ability to be fit parents is questioned and they feel pressured to prove their parenting abilities to others, for instance, the social work services.<sup>59</sup> There is also the misconception that they will be unfair to their children as they are unable to take care

<sup>55</sup> I Heijden ‘Avoiding Harm, Respecting Rights: Facilitating Person-centred, Disability-inclusive Informed Consent in Sexual and Reproductive Health Settings (Experience from Uganda & Rwanda)’ 2023 <[https://www.hi-us.org/sn\\_uploads/document/Disability-inclusive-informed-consent-in-SRH-RS-19.pdf](https://www.hi-us.org/sn_uploads/document/Disability-inclusive-informed-consent-in-SRH-RS-19.pdf)> accessed 19 August 2024

<sup>56</sup> E Bell and others ‘Safeguarding and consent in sexual reproductive health services when supporting persons with intellectual and sensory disabilities’ *Leonard Cheshire and Women’s Integrated Sexual Health (WISH) Programme* 2023 <[https://kayaconnect.org/pluginfile.php/649516/block\\_html/content/Safeguarding%20and%20Informed%20Consent%20Report%20English](https://kayaconnect.org/pluginfile.php/649516/block_html/content/Safeguarding%20and%20Informed%20Consent%20Report%20English)> accessed 20 August 2024

<sup>57</sup> Compilation by Advocacy for Women with Disabilities Initiative (AWWDI), Legal Defence and Assistance Project (LEDAP), and Women Enabled International (WEI) <<https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/StandardHealth/AdvocacyWomenDisabilitiesInitiative.docx>> accessed 20 August 2024

<sup>58</sup> OHCHR (n.52)

<sup>59</sup> Brandeis ‘Stigma and Stereotypes Facing Mothers with Disabilities’ 2017 <<https://heller.brandeis.edu/parents-with-disabilities/pdfs/twitter-stigma-1.pdf>> accessed 20 August 2024

of their children.<sup>60</sup> There is also the belief that disability is hereditary which has stopped many women from giving birth.

According to a 2015 report from Plateau State, women with disabilities in Nigeria face significant challenges accessing adequate healthcare due to poor treatment by medical personnel, inaccessible services, and financial constraints. As a result, they may avoid seeking necessary antenatal care during pregnancy, increasing the risk of complications during pregnancy and childbirth. Health service providers in Nigeria are more inclined to opt for Caesarean sections for women with disabilities. It also revealed that families of women with mental disabilities sometimes resort to implanting contraceptive devices without their consent to prevent pregnancy in cases of potential sexual abuse. There are also reports of families forcibly confining or sterilising WGWDs for protective reasons, although forced sterilisation is not extensively documented in Nigeria.<sup>61</sup>

*Article 23 of the CRPD* mandates State parties to eliminate all forms of discrimination against persons with disabilities regarding parenthood, fertility, family life, relationships, marriage and family planning. Women with disabilities often experience low-quality care when accessing maternal health services. This form of ill-treatment could discourage them from seeking proper maternal healthcare. In instances where information is available on maternal and newborn health, it is usually not in the accessible format. Women with disabilities usually encounter gross violations of their rights when it comes to parenting as a result of being regarded to be asexual, dependent and incapable of caring for their offspring.<sup>62</sup>

### 6.3.2 Abuse and Absence of Respect of Dignity

WGWDs face abuse when they are treated without dignity in accessing sexual and reproductive health services. For girls, this is compounded by age as they are believed to be asexual both based on their age and disabilities. Research shows that when a hearing impairment or albinism co-existed with adolescence, acceptance of the adolescent was especially hindered.<sup>63</sup> In contrast, being married or having at least a basic level of education increased the acceptability of disability. The service providers, family members, and even other patients were engaged in this discriminatory behaviour.

They can also be subject to abusive relationships which they will have a hard time leaving. If she has children, there is also a high risk of losing her children especially if her partner is without disabilities.<sup>64</sup> Every human is entitled to be treated with dignity and this is upheld in many international instruments including the 1999 Constitution of the Federal Republic of Nigeria.<sup>65</sup>

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<sup>60</sup> Ibid.

<sup>61</sup> Ibid.

<sup>62</sup> Women Enabled International 'Sexual and Reproductive Health and Rights of Women and Girls with Disabilities' 2020 <<https://womenenabled.org/wp-content/uploads/Women%20Enabled%20International%20Facts%20-%20Sexual%20and%20Reproductive%20Health%20and%20Rights%20of%20Women%20and%20Girls%20with%20Disabilities%20-%20ENGLISH%20-%20FINAL.pdf>> accessed 20 August 2024

<sup>63</sup> Virpi Mesiäislehto and others 'Disparities in Accessing Sexual and Reproductive Health Services at the Intersection of Disability and Female Adolescence in Tanzania', *International Journal of Environmental Research and Public Health*. [2021] 18(4) <<https://doi.org/10.3390/2Fijerph18041657>> accessed 21 August 2024

<sup>64</sup> Ibid.

<sup>65</sup> Section 34

### 6.3.3 Stereotypic Services, Stigmatisation and Discrimination

Women and girls face discrimination while trying to access sexual and reproductive health services. Stigma and stereotypes significantly hinder the SRHRs of girls and young women with disabilities. They face societal taboos, limited discussions about sexuality, and misconceptions about their sexual behaviour. Structural discrimination, influenced by gender and disability stereotypes, affects their autonomy and access to sexual and reproductive health services. Dominant patriarchal norms and societal perceptions of beauty further compound their challenges, leading to disempowerment and marginalisation. Girls and young women with disabilities, especially those from historically disadvantaged groups, experience intersecting forms of discrimination, worsening their vulnerabilities. Those with multiple impairments face heightened stigma and control, limiting their agency and increasing their risk of sexual violence.<sup>66</sup>

Many health providers are not skilled in handling the health concerns of women with disabilities because they do not have sufficient knowledge of disability. They sometimes demonstrate a lack of sensitivity, care and empathy for women and girls with disabilities due to their insufficient knowledge. The health providers also fuel myths and discriminatory stereotypes about women with disabilities. This hostile nature is a major barrier that denies women with disabilities their sexual and reproductive rights and a slim chance of offering information about contraceptives and, the prevention of sexually transmitted diseases and reproductive cancers. This discourages them from visiting the clinic or asking questions relating to sexual and reproductive health.

### 6.3.4 Forced Sterilisation and Contraceptives Services

WGWDs are often forced to use contraception to control menstruation, sexual expression or fertility, and this can occur, for example, in the form of the insertion of an intrauterine device (IUD). They are also not allowed to make choices on their own. An example of this is forced sterilisation. Forced sterilisation is the involuntary or coerced removal of a person's ability to reproduce, often through a surgical procedure referred to as a tubal ligation. Forced sterilisation is a human rights violation and can constitute an act of genocide, gender-based violence, discrimination, and torture.<sup>67</sup>

Forced sterilisation is a grave violation of human rights, particularly affecting women and girls with disabilities. This practice stems from systemic prejudice and discrimination, denying these individuals their right to bodily integrity and reproductive autonomy. It reflects broader societal attitudes that view disability as a personal tragedy and justify coercive measures. The lack of accessible sexual education and support services worsens the vulnerability of women with disabilities to forced sterilisation.<sup>68</sup> WGWDs are subject to forced hysterectomies to control their menstrual cycles, to prevent pregnancy as a result of sexual abuse or because of misconceptions and discriminatory attitudes about their

<sup>66</sup> UN 'Sexual and reproductive health and rights of girls and young women with disabilities' *Report of the Special Rapporteur on the rights of persons with disabilities* 2017

<[https://www.ohchr.org/Documents/Issues/Disability/A\\_72\\_133\\_EN.docx](https://www.ohchr.org/Documents/Issues/Disability/A_72_133_EN.docx)> accessed 20 August 2024

<sup>67</sup> International Justice Resource Center 'Forced Sterilization as a Human Rights Violation' <<https://ijrcenter.org/forced-sterilization/#:~:text=Forced%20sterilization%20is%20the%20involuntary,viole%2C%20discrimination%2C%20and%20torture>> accessed 20 August 2024

<sup>68</sup> Human Rights Watch 'Sterilisation of Women and Girls with Disabilities; A Briefing Paper' 2011 <<https://www.hrw.org/news/2011/11/10/sterilization-women-and-girls-disabilities>> accessed 20 August 2024



parenting abilities. Forced sterilisation occurs when financial or other incentives, misinformation, or intimidation tactics are used to pressure an individual into undergoing the procedure. WGWDs are particularly vulnerable to forced sterilisations performed under the auspices of “protection” or legitimate medical care.

International human rights standards condemn forced sterilisation as a violation of various human rights, including the right to bodily integrity, privacy, and informed consent. Various UN bodies and conventions have issued recommendations and guidelines to prohibit and prevent forced sterilisation, emphasising the importance of ensuring free and informed consent, providing accessible information, and involving women with disabilities in decision-making processes.<sup>69</sup> The UN Special Rapporteur on Torture (and other cruel, inhuman or degrading treatment or punishment) categorically stated that forced sterilization of women with disabilities is a violation of the provisions of the Convention against Torture and also inconsistent with the meaning of ‘goodwill’ in Article I notwithstanding such inhumane act is legalised in any country.<sup>70</sup>

## 7.0 A Collaborative Approach

From the discussions on the access of WGWD to SRHS, it is evident that every stakeholder has a role to play. This includes the government, the health service providers and the caregivers. The government has an important role in addressing discrimination against women and girls with disabilities in Nigeria. The government has a role to make laws to protect minority rights but Nigeria lacks adequate legislation specifically for the health of persons with disabilities. Existing laws are poorly implemented, largely because many legal instruments related to health are merely policies rather than enforceable laws. For example, the Discrimination Against Persons with Disabilities Prohibition Act<sup>71</sup> includes penalties for buildings with barriers to physical access for PWDs, yet many buildings still lack necessary accommodations like ramps. Furthermore, Nigeria is a signatory to various international agreements but often fails to domesticate them effectively, resulting in a lack of proper implementation plans. The enforcement of laws and policies significantly relies on health service providers, who often perpetuate discrimination. There is a pressing need for education and training among service providers to improve their ability to assist persons with disabilities, particularly regarding sexual and reproductive health. A notable example is shared by the Executive Director of the Deaf Woman Aloud Initiative, who expressed frustration over communication barriers in healthcare settings due to the lack of sign language proficiency among medical staff. This emphasises the critical need for interpreters and better training for healthcare professionals.<sup>72</sup>

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<sup>69</sup> Ibid.

<sup>70</sup> OHCHR Special Rapporteur on Torture. Retrieved March 20, 2024, from <[https://www.ohchr.org/documents/hrbodies/hrcouncil/regularsession/session22/a.hrc.22.53\\_english.pdf](https://www.ohchr.org/documents/hrbodies/hrcouncil/regularsession/session22/a.hrc.22.53_english.pdf)> accessed 20 August 2024

<sup>71</sup> Ibid, Section 8

<sup>72</sup> S Boise and S Oko ‘Bridging the healthcare gap for persons with disabilities’ *2023 Nigeria Health Watch* <https://articles.nigeriahealthwatch.com/bridging-the-healthcare-gap-for-persons-living-with-disabilities/?amp=1>. accessed 20 August 2024

## 7.1 Personal Experiences and Community Support

Personal experiences reveal that negative attitudes from healthcare providers can deter individuals with disabilities from seeking necessary services. Many have faced judgment, unwelcoming behaviour, and substandard care. The role of caregivers and community relationships is also vital; supportive relationships can enhance access to healthcare. A participant in a South African study illustrated this by describing how her parents were initially unhelpful, but she found support from a nurse who listened and assisted her. Overall, addressing the discrimination faced by women and girls with disabilities in Nigeria requires comprehensive legal reform, effective implementation of existing laws, and improved training for health service providers. Additionally, fostering positive community relationships is essential for enhancing access to healthcare services.

## 8.0 Conclusion

The various SRHS of WGWD have been addressed in this paper, including the various ways the right to access these services are infringed upon. PWD form a major part of the population, therefore, their rights should be addressed. WGWD are faced with compounded stereotypes, thereby making it more important to discuss their rights.

## 9.0 Recommendations

Women and girls are vulnerable and prone to abuse; therefore, the law needs to specially protect them as lack of intervention would increase the barriers and infringements they face. In light of the examination made in this paper, the following informed recommendations are now proposed;

- 1.0 Laws should be made to address specifically, the sexual and reproductive health rights of women and girls with disabilities as the laws in place are inadequate to cater for their needs.
- 2.0 There should be structures in place to ensure compliance and implementation. Implementation done should be made to be seen by all for deterrence. Law can come in to ensure enforcement. Broad provisions can prevent enforcement of these laws in their particular contexts.
- 3.0 All stakeholders should be involved in supporting and ensuring access of WGWDs to SRH services. A holistic intervention should be carried out. There should be a collaboration between NGOs, activists, agencies to see to the implementation of these policies and make facilities available to make the work easier for women with disabilities.
- 4.0 To uphold right to privacy and communication, adequate and timely delivery of accessible information should be encouraged. Strategies should be implemented to provide information in accessible formats and utilise various communication channels to reach individuals with disabilities effectively.
- 5.0 Training health professionals in disability inclusion is essential. This includes incorporating disability content into pre-service and in-service training programs for midwives, doctors, and nurses, with a focus on competency areas such as disability sensitisation, informed consent, communication skills, disability identification, and understanding the relationship between pregnancy and impairment.

6.0 The provisions of the Discrimination against Persons with Disabilities (Prohibition) Act, 2018 and other laws against sexual abuse and violence and the punishments should be publicised widely for the purpose of deterrence. Parents, care givers and the society should be discouraged from carrying out activities that involve abuse of access to services. Governments need to maintain a strict implementation of laws and adherence especially as it regards sexual and reproductive health.

Thus, there will be improvements to the right to access SRHS of WGWDs in Nigeria if these recommendations are carefully considered with a view to amending the legal framework to accommodate and incorporate the suggestions made above.