Ensuring Equal and Inclusive Rights to Access Sexual and Reproductive Health Services for Adolescent Girls with Disabilities in Africa

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Abstract

In many African societies, access to sexual and reproductive health care services for adolescent girls remains very problematic. This is due to a number of reasons including socio-cultural factors, influence of religion, negative attitudes of health care providers and legal and policy barriers. The situation is further compounded for adolescent girls with disabilities as many of them are perceived as asexual and cannot make decisions about their sexual and reproductive health. Unfortunately, laws and policies related to sexual and reproductive health and rights (SRHR) of adolescent girls with disabilities tend to exclude their views, reinforcing stigma and discrimination against them. Using the substantive equality and inclusivity lens, this article argues that if adolescent girls with disabilities are to live a fulfilling and healthy life, they must have access to sexual and reproductive health services on an equal basis with others. More importantly, laws and policies to address gaps in access to SRHR services for adolescent girls with disabilities must adhere to rights-based principles such as respect for dignity, non-discrimination, participation and accountability which are entrenched in different human rights instruments. Drawing exemplars from across the region, the

paper notes that these human rights instruments require African governments among other things to remove different barriers to access to SRHR services for adolescent girls with disabilities.

Keywords

access – inclusive – adolescents – girls – disabilities – sexual and reproductive health and rights – Africa

1 Introduction

Adolescence can be a difficult period, especially for women in Africa because of reasons such as lack of access to sexual and reproductive health (SRH) services.[1] For the purpose of this paper, the word adolescence is used according to the definition of the World Health Organisation (WHO) to mean a phase of life between childhood and adulthood from 10 to 19 years of age.[2] Sub-Saharan Africa has the highest proportion (32%) of young people.[3] Although the stage of pregnancy for adolescence is critical as it marks the transition from dependant to being providers and adolescents' health and sexual choices during that period shape their future, they still face challenges related to access to SRH services.[4] In fact, for many adolescents in Africa, many countries still struggle to meet their sexual and reproductive health and rights (SRHR) needs. Therefore, the continued high prevalence of HIV, teenage pregnancy, and unsafe abortion among adolescents in the region.[5] The situation worsens for adolescent

1 Omolade Olomola and Folakemi Ajagunna, 'Knowledge and Access to Reproductive Health Rights among Adolescents in Ibadan, Nigeria' (2020) 28(3) African Journal of International and Comparative Law 401, 401.

2 World Health Organisation, 'Adolescent Health' <https://www.who.int/health-topics/adolescent-health#tab=tab_1> accessed 14 July 2024.

3 World Health Organization, 'Sexual and Reproductive Health Factsheet' <https://www.afro.who.int/sites/default/files/2020-06/Sexual%20and%20reproductive%20health-%20Fact%20sheet%2028-05-2020.pdf> accessed 14 October 2024.

4 Oluremi A Savage-Oyekunle and Annelize Nienaber, '"Adolescents" Access to Emergency Contraception in Africa: An Empty Promise' (2017) 17(2) African Human Rights Law Journal 475, 482.

5 Anthony Idowu Ajayi, Emmanuel Oloche Otukpa, Meggie Mwoka and Caroline W Kabiru and others, 'Adolescent Sexual and Reproductive Health Research in Sub-Saharan Africa: A Scoping Review of Substantive Focus, Research Volume, Geographic Distribution and Africa-led Inquiry' (2021) 6 BMJ Global Health e004129, 2.

girls with disabilities because their views are excluded from many laws and health policies within their countries. Furthermore, they also face discrimination in accessing SRH services due to social perceptions that people with disabilities are asexual and are incapable of making decisions about reproduction or sexuality. As a result, this leads to poor SRH outcomes for adolescent girls with disabilities.

To show international commitment to furthering the SRHR of everyone on an equal basis, including adolescent girls with disabilities, human rights instruments such as the Universal Declaration of Human Rights (UDHR),[6] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[7] the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW),[8] and the Convention on the Rights of the Child (CRC),[9] provide guidelines on how the right to health which embeds SRHR must be enjoyed by everyone. These instruments also require states to come up with certain measures that will ensure that everyone within their jurisdictions enjoys this right without discrimination. To further show commitment to protecting the rights of people with disabilities (PWD), including their SRHR, instruments such as the Convention on the Rights of Persons with Disabilities (CRPD)[10] were introduced by the United Nations system. The CRPD is a disability-specific instrument that provides extensive provisions on the meaning and scope of the right to health, including SRH, which are applicable to all persons with disabilities (PWDs), including adolescent girls.

On the regional plane, the Protocol to the African Charter on the Rights of Persons with Disabilities in Africa also provides specific protection and gives meaning to the SRHR of PWDs in Africa, including adolescent girls with disabilities.[11] Other African human rights instruments such as the African Charter

6 Universal Declaration of Human Rights (UDHR) (adopted 10 December 1948 UNGA Res 217 A (III)).

7 International Covenant on Economic, Social and Cultural Rights (ICESCR) (adopted 16 December 1966, entered into force 3 January 1976), UN Doc A/RES/2200A (XXI).

8 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (adopted 18 December 1979) UN Doc A/RES/34/180.

9 Convention on the Rights of the Child (1989) (adopted 20 November 1989, entered into force 2 September 1990) UNTS 1577, 3.

10 Convention on the Rights of Persons with Disabilities (CRPD) (adopted 13 December 2006, entered into force 3 May 2008) UNTS 2515, 3.

11 The Protocol was adopted in 2018 as the Protocol on the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa, adopted 29 January 2018. It is the legal framework based on which member states of the African Union are expected to formulate disability laws and policies to promote disability rights in their countries.

on Human and People's Rights (ACHPR),[12] the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (African Women's Protocol/ Maputo Protocol)[13] and the African Charter on Rights and Welfare of the Child (ACRWC)[14] are instrumental in regulating the protection of the right to access SRH services without discrimination on the basis of gender, sex, and disability. Many African countries have domesticated some regional and international human rights instruments. However, some of these laws and policies are not inclusive, and this reinforces stigma and discrimination against adolescent girls with disabilities. In light of the above, this paper critically examines the extent to which regional and international human rights instruments ensure inclusivity and non-discrimination in as far as access to SRH services by adolescent girls with disabilities in Africa is concerned. This article draws on examples from African countries to show access to SRH services by adolescent girls with disabilities and how this reinforces the stigma faced by these girls. It focuses on four human rights principles, namely, respect for dignity, non-discrimination, participation and accountability. The choice of these rights is a matter of convenience and does not in any way show their importance over other rights. They serve as a good illustration of how SRHRS of adolescents with disabilities are largely unmet in Africa.

The article comprises six parts. Following this introduction, the second section provides an overview of adolescents with disabilities. The third section discusses the standards that African states have set for adolescents in matters related to their sexual and reproductive lives. The fourth section explores the barriers faced by adolescent girls with disabilities in accessing SRH services. The fifth section analyses how regional and international human rights instruments ensure inclusivity and non-discrimination regarding access to SRH services by adolescent girls with disabilities. Section six concludes and provides recommendations for ensuring that young girls with disabilities enjoy access to SRH services on an equal basis with other adolescent girls without disabilities.

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12 African Charter on Human and Peoples' Rights (Banjul Charter) (adopted 27 June 1981, entered into force 21 October 1986) OAU Doc CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982).

13 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) (adopted 11 July 2003, entered into force 25 November 2005) AU Doc CAB/LEG/66.6.

14 African Charter on the Rights and Welfare of the Child adopted 11 July 1990, entered into force 29 November 1999) OAU Doc CAB/LEG/24.9/49 (1990).

It is important to conceptualise disability before giving an overview of adolescents with disabilities in the African context. According to the World Health Organisation (WHO), there are three dimensions of disability. The first dimension relates to impairment of a person's physical and mental functions. The second relates to the restriction of activities, such as walking, hearing, and seeing. The third refers to a person's restriction to participate in usual daily activities, such as working, engaging in social and recreational activities, and obtaining healthcare and preventive services.[15] In 2021, the United Nations Children's Fund (UNICEF) estimated that 230 million children worldwide between the ages of zero and 17 years have disabilities.[16] Mathabela, Madiba, and Modjadji assert that more than 80% of adolescents with disabilities reside in developing regions such as Eastern and Southern Africa,[17] and most of these children live in rural areas.[18] Furthermore, Africa is believed to have a high prevalence of severe and moderate disabilities compared to other regions in the world.[19] There is no specific data on the number of adolescent girls living with disabilities in sub-Saharan Africa. This is due to some of the challenges associated with data collection. However, studies have documented the numerous setbacks faced by adolescent girls with disabilities in the region. For example, these girls face stigma, discrimination and social exclusion, which then impact their SRHR.[20] Although the experiences of adolescents with disabilities differ depending on their disabilities, it is generally accepted that adolescents with disabilities tend to experience more difficulties in accessing SRH services compared to adolescents without disabilities.[21]

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15 Center for Disease Control and Prevention, 'Disability and Health Overview' <https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html> accessed 2 April 2024.

16 See also Pauline Samia, Katherine Oyieke, Barnabas Kigen and Susan Wamithi, 'Education for Children and Adolescents living with Disabilities in Sub – Saharan Africa: The Gaps and Opportunities' (2022) Frontiers in Public Health 10:779351, 1.

17 Bheki Mathabela, Sphiwe Madiba and Perpetua Modjadji, 'Exploring Barriers to Accessing Sexual and Reproductive Health Services Among Adolescents and Young Persons with Physical Disabilities in South Africa' (2024) 21(1) International Journal of Environmental Research and Public Health 1, 1.

18 Samia (n 16) 1.

19 ibid.

20 Nicola Jones, Elizabeth Presler-Marshall and Maria Stavropoulou, 'Adolescent with Disabilities: Enhancing Resilience and Inclusive Development for Adolescent with Disabilities' (*ODI*, 2018) <https://odi.org/en/publications/adolescents-with-disabilities-enhancing-resilience-and-delivering-inclusive-development/> accessed 14 October 2024.

21 ibid.

3 Conceptualising Adolescents with Disabilities

Despite international recognition of the right to access basic healthcare, adolescents, including those with disabilities, still do not enjoy this right due to negative social perceptions. Due to religious and cultural factors in some parts of the region, some people hold the view that adolescents should not engage in sexual activities or seek contraceptive services.[22] This is often based on the misinterpretation of the sexuality of adolescents. The patriarchal and sexist nature of many African societies regarding open discussions of the SRHR of adolescents is the greatest deterrent against knowledge of sexual and reproductive health rights of adolescents.[23] Sometimes, parents shy away from discussing or educating their adolescent children on sex and sexual rights because such topics are considered taboo and there is fear that such discussions may stimulate adolescents' interest in sexual activities.[24] Furthermore, parents rarely discuss sexual matters with their adolescent children because they believe that such matters are reserved for marriage.[25] As a result, adolescents resort to getting this information from their peers who sometimes share inaccurate information with them.[26] In addition, adolescents who appear to be interested in topics related to sex are discriminated against as they are viewed as stubborn and suspected of indulging in sexual activities.[27] In some cases, sexual activities among adolescent boys are promoted, while for adolescent girls they are condemned. This is arguably attributable to the patriarchal structure of African societies and deep-rooted gender inequality.

As a result of these challenges, the SRHR of adolescents remains acutely unmet in Africa. This, in turn, led to poor SRHR outcomes for adolescents in the region. For example, the WHO has noted that 78% of women in Liberia and 77% of females in the Congo had first sexual intercourse at the age of 18 years.[28] It is further noted that at age 18, 68% and 66% of men in Congo

22 For detailed discussion, see Ebenezer Durojaye, 'Access to contraception for adolescents in Africa: A Human Rights Challenge' (2011) 44 Comparative and International Journal of Southern Africa 1, 1–29.

23 Olomola (n 1) 411–412.

24 Phabian IG Sagnia, Atadafe P Gharoro and Alphonsus R Isara, 'Adolescent – Parent Communication on Sexual and Reproductive Health Issues Amongst Secondary School Students in Western Region 1 of The Gambia' (2020) 12 African Journal of Primary Health Care and Family Medicine 1, 1–6.

25 ibid.

26 Olomola (n 1) 412.

27 ibid.

28 World Health Organization, 'Sexual and Reproductive Health Factsheet' <https://www.afro.who.int/sites/default/files/202006/Sexual%20and%20reproductive%20health-%20Fact%20sheet%2028-05-2020.pdf> accessed on 14 October 2024.

and Angola respectively had had their first sexual intercourse.[29] About 31% of women between the ages of 20 and 24 in the African region were married before the age 18.[30] The top five countries in the region for early marriage were Niger (76%), Central African Republic (68%), Chad (67%), Mali (54%) and South Sudan (52%).[31] The African region has the highest number of births of women under 15.[32] Overall, contraception use among adolescents girls in Africa seems to be one of the lowest in the world compared to other regions. A study has shown that at 10.2%, Africa has the highest unmet need for contraception, compared to Central and Southern Asia at 3.1%.[33] Poor contraceptive use can lead to high teenage pregnancy, unsafe abortion, high maternal mortality, and high fertility rate. For example, the birth rate in South Asia from 2015 **to** 2020 is 26 per 1000 girls aged 15–19 years, whereas the corresponding rate in sub-Saharan Africa is 104 per 1000 girls aged 15–19 years.[34]

With reference to adolescents with disabilities, there is a perception that caregivers and parents may struggle to recognise their children's capacity for romantic or sexual development, thereby excluding them from the social experiences enjoyed by their peers.[35] This has the risk of undermining the sexual interests of adolescents with disabilities and exacerbate their risk of sexual exploitation.[36] Furthermore, adolescents with disabilities are often out of touch with current trends of sexuality and sexual experiences of their non-disabled peers because of their limited participation in social networks outside school.[37] This can impede access to contraceptive services. For a group of people who are deemed asexual, seeking access to contraception can trigger negative and judgmental attitudes on the part of healthcare providers. Although there are no general data on the use of contraception among adolescents with disabilities,

29 ibid.

30 ibid.

31 ibid.

32 Lucyline Nkatha Murungi and Ebenezer Durojaye, 'The Sexual and Reproductive Health Rights of Women with Disabilities in Africa: Linkages between the CRPD and the African Women's Protocol' (2015) 3 African Disability Rights Yearbook 3, 3.

33 Vladimíra Kantorová, Mark C. Wheldon, Aisha N. Z. Dasgupta and Philiph Ueffing and others, 'Contraceptive Use and Needs Among Adolescent Women Aged 15–19: Regional and Global Estimates and Projections from 1990 to 2030 from a Bayesian Hierarchical Modelling Study' (2021) 16 PLos One 1, 6.

34 Venkatraman Chandra-Moul and Elsie Akwara, 'Improving Access to and Use of Contraception by Adolescents: What Progress Has Been Made, What Lessons Have Been Learnt, and What Are the Implications for Action?'(2020) 66 Best Practice in Research and Clinical Obstetrics and Gynaecology 107, 108.

35 Murungi (n 32) 3.

36 Mathabela (n 17) 2.

37 ibid.

individual country studies have shown a low adoption of contraception among women and girls with disabilities. For example, a study on contraceptive use among women with disabilities in Ethiopia reveals these women are less likely to use contraceptives, with a prevalence of 21.7% in Gondor City and 44.4% in Addis Ababa.[38] Another study in Nigeria reveals that contraceptive knowledge and use are very low among young people with disabilities. The study reveals that more than half (51.4%) of those who have ever had sexual intercourse were unaware of any modern contraceptive methods.[39] It further shows that of the 35 sexually experienced respondents, 12 (34%) had used a modern contraceptive while about two thirds (66%) had not used any.[40]

4 Challenges Faced by Adolescents with Disabilities in Africa

While many African countries struggle to meet the SRHR needs of adolescents in general, the situation of adolescents with disabilities seem worse. The barriers faced by adolescents with disabilities are almost uniform across various settings. They include discrimination, knowledge and communication problems with health care workers, physical barriers to healthcare access, social barriers such as personal attitudes towards SRH services, and affordability of service providers.[41] Generally, adolescents with disabilities have a high chance of being stigmatised and discriminated against compared to their non-disabled counterparts.[42] It is widely acknowledged that the greatest deterrent is prejudice, social isolation, and discrimination, with women adolescents more at risk.[43] Female adolescents in communities where boys are valued more than girls suffer the brunt of stigma and discrimination because such communities invest more resources to promote the welfare of adolescent boys. This is evidenced by the fact that in some underprivileged families, when an adolescent

38 Abebe Alemu Anshebo, Yilma Markos, Sujit Behera and Natarajan Gopalan, 'Contraceptive Dynamics Among Women with Disabilities of Reproductive Age in Ethiopia: Systematic Review' (2024) 13 Systematic Reviews 1,1.

39 Folakemi O Olajide, Akinlolu G Omisore, Olujide O Arije1 and Olusegun T Afolabi and others, 'Awareness and Use of Modern Contraceptives Among Physically Challenged In-School Adolescents in Osun State, Nigeria' (2014) 18 African Reproductive Health Journal 87.

40 ibid.

41 Mathabela (n 17) 2.

42 ibid.

43 Nora E Groce, 'Adolescents and Youth with Disability: Issues and Challenges' (2004) 15 Asia Pacific Disability Rehabilitation Journal 13, 16.

girl with a disability falls ill and needs a simple antibiotic, they take days to buy medication for her compared to when a male adolescent with a disability falls ill.[44] Although this is not a general practice, the fact that adolescents with disabilities are treated differently in some families underscores the prejudice and discrimination they face in society.

Furthermore, adolescents with disabilities who belong to ethnic and minority populations are further marginalised due to their different linguistic and cultural traditions and experience poorer sexual and reproductive health outcomes.[45] Adolescent girls with disabilities also suffer discrimination from belonging to disadvantaged groups such as indigenous communities.

In terms of international human rights standards, PWDs must have equal rights in every facet of their lives, including the right to access SRH services.[46] However, negative perceptions that PWDs are not sexually active contribute to the failure of adolescents with disabilities to access SRH services on a basis equal to people without disabilities. According to Chappell, this belief that adolescents with disabilities are asexual is evidenced by the fact that adolescent boys with disabilities (especially those with physical impairments) tend to be teased by their non-disabled colleagues about their ability to engage in sexual activities.[47] This led to the marginalisation of adolescent boys with disabilities as a result of their physical impairments.[48] Although this is not always true, this is the perception of some members of society.

Despite negative perceptions about the sexuality of adolescents with disabilities, studies have revealed that, generally, adolescents with disabilities are as likely to be sexually active as their counterparts without disability.[49] A study by Murphy and Young established that the sexuality expressions of adolescents with disabilities are similar to those of their peers without disabilities.[50] Furthermore, adolescents with disabilities have hopes and desires for marriage, children, and fulfilling sex lives.[51]

One of the barriers faced by PWDs, including adolescent girls with disabilities, is the fact that health personnel treat them with indignity. This manifests

44 ibid.

45 ibid.

46 See International Convention on the Rights of Persons with Disabilities.

47 Paul Chappell, '(Re)thinking sexual access for adolescents with disabilities in South Africa' (2016) African Disability Rights Yearbook 124, 129.

48 ibid.

49 Mathabela (n 17) 2.

50 Nancy Murphy and Paul C Young, 'Sexuality in Children and Adolescents with Disabilities' (2005) 47 Developmental Medicine and Child Neurology 640, 640.

51 ibid.

in different ways such as health care workers making medical decisions on behalf of PWDs and ignoring principles such as autonomy and dignity.[52] This happens despite the emphasis made in General Comment No. 6 by the Committee on the Rights of Persons with Disabilities (CRPD Committee) that PWDs must receive health services on the basis of free and informed consent.[53] As a result, the question arises whether PWD, including adolescent girls with disabilities, have the capacity to make informed decisions about their sexual and reproductive choices.[54]

5 Access to Sexual and Reproductive Health in Human Rights Law

5.1 *Non-discrimination*

The non-discrimination principle is the foundation of human rights law and is included in all human rights treaties at regional and international levels.[55] It is highlighted in the ICESCR, which is the first human rights instrument to clearly lay down the necessary steps to realise the right to health, including sexual and reproductive health and rights.[56] Article 2(2) of the ICESCR provides that states have an obligation:

> to ensure that the rights contained in the present Covenant will be applied without discrimination of any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.[57]

The Committee on Economic, Social and Cultural Rights argued that prohibiting discrimination on the grounds of 'other status' explicitly applies to discrimination on the grounds of disability.[58] Additionally, although the ICESCR does

52 Murungi (n 32) 3.

53 Committee on the Rights of Persons with Disabilities, General Comment No. 6 on Equality and Non-discrimination, CRPD/C/GC/6, para 66.

54 Murungi (n 32) 3.

55 ibid para 4.

56 Dina Bogecho, 'Putting it to Good Use: The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health' (2004) 13 Southern California Review of Law and Women's Studies 229, 236.

57 ICESCR, art 2(2) and preamble.

58 CESCR General Comment No. 5: Persons with Disabilities Adopted at the Eleventh Session of the Committee on Economic, Social and Cultural Rights, on 9 December 1994 (Contained in Document E/1995/22), para 5.

not explicitly refer to PWDs to the extent that special treatment is necessary, it obliges states to take appropriate measures 'to the maximum extent of their available resources, to allow PWDs to rise above any drawbacks, in terms of the enjoyment of the rights enumerated in the ICESCR flowing from their disability …'.[59] We argue that some of these rights include sexual and reproductive health rights, particularly access to contraceptive information and services. Furthermore, the ICESCR requires states to promote progressive realisation of rights such as the right to health within their available resources. This obligation requires states to 'take positive steps to reduce structural hindrances and to give special proper treatment to PWDs in order to achieve the objectives of full participation and equality within society for all PWDs.'[60]

The CRPD, which is the first treaty to address disability rights globally, is very instrumental in promoting the principle of equality and non-discrimination in relation to access to rights by PWDs.[61] The objective of the CRPD is to 'promote, protect and ensure the complete and equal enjoyment of all human rights and fundamental freedoms by all PWDs, and to further the respect for their inherent dignity'.[62] With respect to promoting equality and non-discrimination, the CRPD defines 'discrimination on the basis of disability' as:

> any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.[63]

This provision implies that states must ensure that legislation, policies and practice do not discriminate. Therefore, to ensure that there is 'equal and effective legal protection against discrimination', states are obliged to enact specific and comprehensive anti-discrimination legislation, accompanied by the provision of appropriate and effective legal remedies and sanctions in relation to intersectional discrimination.[64] Furthermore, in accordance with the principles of substantive equality, states are allowed to discriminate in favour

59 ibid para 9.
60 ibid.
61 The CRPD was adopted on the 30th of March 2007.
62 CRPD, art 1.
63 CRPD, art 2.
64 Committee on the Rights of Persons with Disabilities, General Comment No. 6 on equality and non-discrimination, CRPD/C/GC/6, para 22.

of PWDs when this is necessary to ensure that PWDs and people without disabilities have equal opportunities. Therefore, to ensure inclusivity and equal access to SRH services, states must enact legislation and create policies and programmes specifically to improve the enjoyment of SRHR of adolescents with disabilities. To ensure inclusivity and equal access to the enjoyment of human rights by PWDs on an equality basis, Article 2 of the CRPD states: 'reasonable accommodation is an integral part of the directly applicable duty of non-discrimination in the context of disability.'[65] Furthermore, Article 2 refers to carrying out, when necessary, appropriate modifications and adjustments, which do not impose a disproportionate or unnecessary burden, so that PWDs can enjoy their human rights on an equal basis with others.[66]

Examples of reasonable accommodation in relation to ensuring access to SRH for adolescent girls with disabilities on an equal footing with non-disabled girls include 'ensuring that existing facilities and information are accessible to the individual with a disability; adjusting equipment; remodelling medical procedures and enabling access to support personnel without unreasonable or undue burden.'[67] Therefore, in line with the obligation imposed on states by Article 2, the state and other non-state actors are obliged to take steps to accommodate female adolescents with disabilities in different settings and ensure that they access sexual and reproductive health services on an equal basis with their non-disabled female counter parts.

In General Comment No. 6, the CRPD Committee attempted to unpack what amounts to protecting PWDs from discrimination. The Committee reiterated that protection against 'discrimination on all grounds' means that all possible grounds of discrimination and their intersections must be taken into account.[68] These grounds include disability, status, race, ethnicity, sex, pregnancy, language, religion, and political affiliation, or a combination of these grounds or any characteristics associated with them.[69] We contend that PWDs often experience discrimination on more than one of the above-mentioned grounds or characteristics. The Committee emphasised that adolescent girls with disabilities often experience multiple and intersectional discrimination,[70] especially regarding their access to sexual and reproductive health services. Therefore, states are obliged to ensure that measures are put in place to

65 CRPD, art 2.
66 ibid.
67 Committee on the Rights of Persons with Disabilities, General Comment No. 6 on equality and non-discrimination, CRPD/C/GC/6, para 23.
68 ibid para 21.
69 ibid.
70 ibid para 36.

eradicate discrimination against adolescent girls with disabilities in accessing sexual and reproductive health services.

The right to health, including the sexual and reproductive health of PWDs, is provided for in Article 25 of the CRPD as follows:

> PWDs have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, and that Member States shall take all appropriate measures to ensure access for PWDs to health services that are gender sensitive.[71]

This is a commendable provision because it encourages equality and inclusion in access to health services that could include SRH services to PWDs, including female adolescents. In addition, Article 25 requires states to provide PWDs with the same range, quality, and standard of free or affordable health care and programmes as provided to other persons.[72] This is a very progressive provision, considering that adolescent girls with disabilities frequently face challenges in accessing sexual and reproductive health services because health personnel rarely ensure that procedures and programmes are adjusted to enable them enjoy these services on an equal basis with non-disabled adolescent girls.

CEDAW, which is a women-specific human rights instrument, has laudable provisions on the prohibition of discrimination. Article 1 defines discrimination against women as follows:

> [A]ny difference, exclusion or limitation made on the premise of sex which has the consequence or purpose of damaging or nullifying the recognition, enjoyment or exercise by women, regardless of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[73]

The right to non-discrimination can be claimed by adolescents with disabilities if healthcare providers discriminate against their access to SRH services. Furthermore, CEDAW provides for the right to health in Article 12. In explaining

71 CRPD, art 25.

72 ibid.

73 National Assembly of People with Disabilities, 'Human Rights of Women and Girls with Disabilities: A Brief Guide to the Intersectional Approach Through the Implementation of CEDAW and CRPD in Ukraine' (*Kyiv*, 2019) <https://ukraine.un.org/sites/default/files/2020-09/cedaw%20crpd%20guide%20eng_compressed.pdf> accessed 6 April 2024.

the normative content of Article 12, the Committee on the Elimination of All Forms of Discrimination against (CEDAW Committee) reiterated the need to give special attention to the health needs and rights of women from disadvantaged and vulnerable groups, including women with physical or mental disabilities.[74] The CEDAW Committee is commended for emphasising the importance of applying the substantive equality principle in ensuring that marginalised groups such as adolescent girls with disabilities are given special attention to ensure that they enjoy reproductive health and rights on an equal footing. Regarding the right to receive family planning information, counselling services, and advice on the number and spacing of children, the CEDAW Committee's General Recommendation 18 on Disabled Women has made it a requirement that states report on any action taken to enable women with disabilities to enjoy equal access to health services, including sexual and reproductive health services.[75] Furthermore, General Recommendation 25 recognises that women with disabilities suffer from multiple forms of discrimination on grounds such as age, disability, ethnic or religious identity, class and caste.[76] Therefore, states must ensure the participation of women and girls with disabilities in all areas of social and cultural life.[77]

Article 2(1) of the UNCRC prohibits discrimination on any basis, including sex, and provides strong protection of children's right to access sexual and reproductive health services.[78] To address discrimination, states need to put in place legislative and administrative measures. The Committee on the Rights of the Child (CRC Committee/ CRC) has strongly advocated for the realisation of the right to sexual and reproductive health services by urging states to ensure universal access to a comprehensive package of sexual and reproductive health interventions.[79] This implies that adolescents have the right to

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74 UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) General Recommendation No 24: Article 12 of the Convention (Women and Health), UN Doc A/54/38/Rev.1, chap 1.

75 UN Division for the Advancement of Women, 'CEDAW General Recommendation No. 18 (1991) on Disabled Women' <https://www.legal-tools.org/doc/ba95ff/pdf/> accessed 7 November 2024.

76 ibid. See also UN Committee on the Elimination of Discrimination Against Women, 'General Recommendation No. 25: on Temporary Special Measures' <https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT/CEDAW/GEC/3733&Lang=en> accessed 30 March 2024.

77 National Assembly of People with Disabilities (n 73) 6.

78 CRC, art 2(1).

79 Reproductive Rights, 'Reproductive Rights Under the Convention on the Rights of the Child', <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Wright_Glo%20Adv_7.15.14.pdf> accessed 6 April 2024.

access short-term and long-term contraceptives, as well as legal and safe abortion. To achieve this, member states must implement child-sensitive health approaches, including 'adolescent-friendly health services which require health practitioners and facilities to be hospitable and sensitive to adolescents … to deliver services that are satisfactory to adolescents.'[80] It is argued that this interpretation implies that the provision of adolescent-friendly services should be adjusted to meet the needs of different categories of adolescents, such as those who are marginalised due to factors such as gender and disability. In addition, to achieve substantive equality for girls with disabilities, states are expected to put in place a variety of positive measures to remedy the various ways that entrenched discrimination results in inequalities.[81]

The United Nations Special Rapporteur on the right to health also clarified the content of the right to health and shared his viewpoints on equality and non-discrimination as important health system characteristics.[82] In the same report, the Special Rapporteur stated that there is a duty for governments to ensure that a health system can easily be accessed by everyone on an equal basis and that negligible people practically enjoy the same access as those who are more privileged.[83] Therefore, states have an obligation to ensure that marginalised members within their countries, such as adolescent girls with disabilities, access healthcare services on an equal basis by distributing sufficient resources to health systems.[84] In terms of substantive equality theory, to achieve equality, one needs to treat those who are different in a different way.[85] This implies that to achieve equality in accessing SRH services by adolescent girls with disabilities, there is a need to come up with diverse actions and programmes that will facilitate the enjoyment of their right to health fully like their non-disabled counterparts.

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80 ReliefWeb, 'Regional Report: Assessment of Adolescents and Youth-Friendly Health Service Delivery: East and Southern Africa' <https://reliefweb.int/report/world/regional-report-assessment-adolescents-and-youth-friendly-health-service-delivery-east?gad_source=1&gclid=CjwKCAjw_e2wBhAEEiwAyFFF04SZPqGpBnW1isNZRLy1pE8G-4cbb-LLR4d5uca-UMPCiLPiY97rWR0C0EEQAvD_BwE> accessed 14 April 2024.

81 Reproductive Rights (n 79).

82 Paul Hunt, 'Report of the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' <https://www.right-docs.org/doc/a-hrc-7-11/> accessed 16 January 2025.

83 ibid.

84 Gillian MacNaughton, 'Untangling Equality and Non-Discrimination to Promote the Right to Health Care for All' (2009) 112 Health and Human Rights 47, 54.

85 Ebenezer Durojaye 'A Gendered Analysis of Section 48(2) (d) of the Zimbabwean Constitution of 2013' (2017) 38 Statute Law Review 34.

In the *Purohit* case,[86] the African Commission addressed discriminatory practices against persons with disabilities by affirming that Articles 2 and 3 of the African Charter are one of the fundamental principles that are not subject to derogation. The Commission affirms that these provisions are so important that all other rights depend on them. In *Eldridge v British Columbia* (*Attorney General*),[87] the Canadian Supreme Court affirmed that states have the obligation to realise substantive equality to health care services for persons with disabilities by ensuring the recruitment of healthcare providers with knowledge of sign language. This decision is very important for eliminating discrimination with respect to access to health care services for people with disabilities.

Regionally, Article 2 of the African Charter provides for 'the enjoyment of rights and freedom of every individual, without distinction of any kind such as race, ethnic group, colour, sex, language, religion, or any other opinion, social origin or another status.'[88] Although the African Charter, like the ICESCR, does not explicitly refer to disability, the term 'another status' can be argued to imply disability. Therefore, the ACHPR can be commended for having such an open provision that implies a mandate on states to ensure that adolescent girls with disabilities enjoy the right to SRHR on the same basis as everyone. To allow adolescent girls with disabilities to enjoy their right to health, Article 16 of the ACHPR mandates states to implement specific actions to make the enjoyment of this right a reality.[89] Furthermore, Article 16 obligates states to identify groups of people experiencing major risks, including adolescent girls with disabilities, and make it a point that they have access to distinct health protection that addresses their specific health problems.[90]

Furthermore, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) is very instrumental in preventing discrimination and can be relied on to claim access to sexual and reproductive health services by adolescents with disabilities. Article 1 of the Maputo Protocol adopts a substantive approach to equality by defining discrimination against women broadly as follows:

> Any differentiation, exclusion or limitation or any variance in treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their

86 [2003] ACHPR Comm. 241/2001, ACHPR AAR Annex VII [49].

87 [1997] 3 SCR 624.

88 African Charter, art 2.

89 ibid art 16.

90 Amnesty International, 'A guide to the African Charter on Human and Peoples' Rights' <https://www.amnesty.org/download/Documents/76000/ior630052006en.pdf> accessed 14 April 2024.

mental status, of human rights and fundamental freedoms in all spheres of life.[91]

Arguably, the Maputo Protocol should be applauded for having such a provision because the right to non-discrimination is fundamental in ensuring access to sexual and reproductive health services for marginalised and vulnerable groups such as adolescent girls with disabilities. Regarding the right to health, Article 14 of the Maputo Protocol provides as follows: 'States Parties shall ensure that the right to health of women, including SRH is respected and promoted.'[92] It is important to note that Article 14 of the Maputo Protocol also explicitly addresses women's reproductive health and rights, including HIV.[93]

The African Commission on Human and People's Rights has highlighted the disparity that exists in HIV infections between women and men and attributed it to issues such as social barriers that prevent access to healthcare, gender inequalities, and discrimination against women and girls.[94] The proposition of the African Commission is argued to also apply to adolescent girls with disabilities, as they are at high risk of being infected and are often victims of sexual violence due to their vulnerable position in society. In the *Purohit* case, which involved patients with mental disabilities, the African Commission affirmed that forced institutionalisation and maltreatment of patients with mental disabilities constituted a violation of articles 2 and 3 of the African Charter dealing with non-discrimination and equal protection of the law.[95] It further affirmed that failing to ensure access to health care services was in violation of Article 16 of the Charter.

Furthermore, the African Commission in General Comment No. 2, remarked that the right to health includes 'the freedom of women to decide on maternity, the number and spacing of births and the right to choose contraception method'.[96] To achieve this, the African Commission obliges states to remove barriers to health services, such as ideology or belief-based barriers.[97] Most of

91 African Women's Protocol, art 1.

92 ibid art 14.

93 ibid.

94 Megan Geldenhuys, Chisomo Kaufulu-Kumwenda, Satang Nabaneh and Karen Stefiszyn, 'The African Women's Protocol and HIV: Delineating the African Commission's General Comment on articles 14(1)(d) and (e) of the Protocol' (2014) 14 African Human Rights Law Journal 682, 699.

95 *Purohit* case (n 86).

96 ACHPR, 'Preface and Paragraph 23 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 Peoples' Rights' <https://achpr.au.int/index.php/en/node/854> accessed 24 April 2024.

97 ibid para 2.

the time, this right is not enjoyed by adolescent girls and the situation is worsened for those with disabilities because their families and society ignore their capability to make the right decisions regarding their reproductive system and sexuality.

Article 9 of the SADC Protocol on Gender and Development provides as follows:

> States Parties shall in accordance with the SADC Protocol on Health and other international human rights instruments to which SADC members are parties, adopt legislation and related measures that take into account their particular vulnerabilities, to protect persons with disabilities.[98]

This is a welcome provision that can be invoked to facilitate the enjoyment of SRHR by adolescents with disabilities.

Article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC) protects the right to health to ensure that it is enjoyed by everyone, including adolescent girls with disabilities. Article 14(1) provides that 'every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health'. The word everyone implies that children with disabilities are included in this provision. Article 14(2) protects reproductive health and rights. Therefore, by virtue of Article 14(1), adolescents with disabilities under 18 years are also covered by Article 14(2), which seeks to reduce infant and maternal mortality.[99] Article 14(2) of the ACRWC is laudable for incorporating reproductive health elements, which include the right to safe maternal health services and the duty of states to ensure the reduction of infant and child mortality rates. Therefore, to reduce infant and maternal mortality rates, states must ensure that all women, including those with disabilities, access safe maternal health care services. Sithole argues that ensuring that all women of reproductive age who include adolescent girls with disabilities access family planning services can go a long way in limiting births that are regarded as high-risk, hence reducing the likelihood of giving birth to a baby that will perish during infancy.[100]

The African Disability Protocol, which is the culmination of the African Union's efforts to create a framework to safeguard the human rights of PWDs

98 SADC Protocol on Gender and Development, art 9.

99 ACRWC, art 14(2).

100 Linet Sithole, 'Women's Right to Access Family Planning and Maternal Health Care Services in Hwange Rural District, Zimbabwe: Challenges and Opportunities' (DPhil thesis, University of Cape Town 2020).

on the African continent, can be hailed for prohibiting discrimination against PWDs in enjoying different rights and accessing different services. It is unique to the African continent in that it takes into account African practices and concerns to improve the lives of PWDs.[101] Articles 5 and 6 proscribe discrimination against PWDs in law and on any ground such as gender, age and race.[102] The Protocol on these two provisions enjoins states to prohibit discrimination on grounds of disability and put in place legislative, administrative, budgetary and other measures to promote equality of PWDs and such measures shall not be considered discrimination.[103] These are commendable provisions capable of addressing ingrained issues of discrimination to ensure that adolescent girls with disabilities access health without being stigmatised.

The discussion above has established that equality and non-discrimination are very important principles that must be adhered to in furthering the realisation of access to SRHR for adolescent girls with disabilities. However, despite regional and international human rights law, adolescents continue to be discriminated against. For instance, the constitutions of some African countries such as Lesotho lack provisions that specifically list disabilities as one of the prohibited grounds of discrimination. Rather, they mention discrimination in other provisions that relate to the rehabilitation, training and retirement of PWDs.[104] Furthermore, the legal frameworks in some African countries 'do not adopt a twin track approach', which as mandated by the CRPD, obligates states to prohibit discrimination against women with disabilities on grounds of sex and disability. This approach recognises that women with disabilities are susceptible to discrimination, abuse and exploitation.[105] In addition, South Africa is considered one of the countries with comprehensive legislation and policies that protect and promote the rights of PWD. However, these laws and policies are deficient because they seem to focus on promoting a few of their rights such as the right to education and the eradication of discrimination and oppression. Little attention has been paid to matters related to sexual expression and relationships. As a result, although adolescents with disabilities are recognised as citizens with equal rights and opportunities as their peers

101 DDP Pathways, 'The African Disability Protocol- A homegrown legal framework to promote disability rights' <https://www.linkedin.com/pulse/african-disability-protocol-homegrown-legal-framework-taurai-chako/> accessed 14 April 2024.

102 African Disability Protocol, arts 5(1), (2) and Article 6(1).

103 ibid arts. 5(2)(b) and 6(3).

104 Itumeleng Shale, 'Sexual and Reproductive Rights of Women with Disabilities: Implementing International Human Rights Standards in Lesotho' (2015) 3 African Human Rights Yearbook 31, 44.

105 ibid.

who do not have disabilities, they have not yet truly emerged as independent sexual citizens.[106]

Although some countries have policies that promote equality in access to services despite disability, the challenge is that most of these policies are outdated. A good example is Zimbabwe, which relied on a 2016–2020 National Health Strategy that had already expired in 2022 and was only renewed at the beginning of 2023. The same applies to the National Adolescent Sexual and Reproductive Health Strategy (ASRH Strategy) II (2016–2020), which was only renewed in 2023.

5.2 *Dignity of the Person*

The term 'human dignity' or 'dignity of the person' is frequently used, especially in the field of human rights, but it is not simple to define.[107] Various definitions of 'human dignity' have been suggested by different scholars and philosophers. The definition that is very common and has been adopted in the human rights space, mainly in human rights instruments, relates to the intrinsic honour that a person deserves because of being a human being; it is the worth that separates humans from animals.[108] Therefore, the natural perception of human dignity is inherent; it cannot be taken away regardless of one's physical or mental condition, degree of autonomy, or capacity to make choices.[109]

The 'dignity of the person' principle was first mentioned in the UDHR. In its preamble, the UDHR states: 'whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world …'.[110] Further, Article 1 of the UDHR reaffirms that: 'all human beings are born free and equal in dignity and rights'.[111] This shows the value and emphasis that the UDHR places on the recognition of the dignity of the person to facilitate the enjoyment of rights and freedoms. The CRPD in its preamble recognises 'the inherent dignity and worth of every human being' as a basis for the rights contained in the CRPD.[112] To show the importance of respecting the dignity of a person in the realisation of the rights of PWDs, Article 3 of the CRPD sets different general principles

106 Mathabela (n 17) 12.
107 Jeffrey A Brauch, 'Preserving true human dignity in human rights law' (2022) 50 Capital University Law Review 115, 117.
108 ibid 118.
109 ibid.
110 UDHR, preamble.
111 UDHR, art 1.
112 CRPD, preamble.

as the cornerstone of the CRPD. Amongst these principles, the recognition of intrinsic dignity and individual autonomy, as well as the freedom to make your own choices and independence of your person, is acknowledged.[113] Therefore, respect for dignity can be invoked by adolescent girls with disabilities when claiming access to SRH on an equal basis with other adolescents without disabilities, including consenting to any medical procedures that might have a bearing on your reproductive system or sexual life.

The CEDAW is very instrumental in advocating for the protection of women's dignity. In its preamble, the CEDAW explicitly acknowledges that extensive discrimination against women 'violates the … respect for human dignity'.[114] In explaining the right of women to health, General Recommendation No. 24 of the CEDAW Committee reiterated the need for member states to 'take proper actions to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity'.[115] This shows the importance of respecting human dignity in furthering the realisation of the right to health, including SRHR of adolescent girls.

Regionally, Article 3 of the African Women's Protocol also reiterates the importance of respecting the dignity of a person. Article 3 provides that 'all women shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights'.[116] Furthermore, it emphasises the need for every woman's right to be respected and for states to implement appropriate measures to prohibit exploitation or degradation of women, as well as to ensure that women are free from inhumane, cruel or degrading treatment, especially when they seek reproductive health services such as abortion or sterilisation.[117] Arguably, coercing or forcing adolescent girls with disabilities to go through medical procedures based on their disability and without informed consent undermines their right to dignity as provided in Articles 3 and 4 of the African Women's Protocol.

The importance of ensuring the dignity of PWDs, including adolescent girls, by allowing them to make decisions about reproduction has been decided by courts. The Indian court in the case of *Suchita Srivastava v Chandigarh Administration*[118] gave a position on allowing disabled women with mental disabilities to make decisions about their reproductive lives. This case involved a

113 CRPD, art 3.
114 CEDAW, preamble.
115 CEDAW General Recommendation 24: Women and Health 02/02/99, para 25.
116 Maputo Protocol, art 3.
117 Maputo Protocol, arts 3 and 4. See also Murungi (n 35) 10.
118 [2009] 11 SCALE 813 N.

20-year old woman who had mild mental impairment and became pregnant. Therefore, the medical board was supposed to assess her condition and determine if she had the capacity to carry her pregnancy to term and the consequences of continuing the pregnancy. Without a clear basis in law and without the consent of the woman, the board decided that her pregnancy should be aborted.[119] The Indian High Court granted an application seeking approval for terminating the pregnancy, taking into consideration the mental disability and the fact that the woman was an orphan who was unable to comprehend the consequences or responsibilities that come with a pregnancy.[120] On appeal, the Supreme Court ruled that, based on the Medical Termination Act of 1971, consent is important to any termination of pregnancy. The court reiterated the importance of getting consent from the woman despite the fact that she lived in an institution and the state was her guardian.[121] The court further explained that the consideration of whether to exercise the right to procreate or not include a woman's rights to dignity, privacy, and bodily integrity.[122] This case is a clear example that intellectual disability should not be used as an excuse to undermine the dignity of adolescent girls with disabilities.

What is important to note from the above discussion is that regional and international human rights instruments regard the dignity of the person as an important aspect of ensuring that women, including adolescent girls with disabilities, enjoy their rights on the same level as their counterparts and that laws and policies are tailored to respect their dignity. These rights include 'the right to be notified of and to have access to safe, efficient, reasonable and acceptable methods of family planning of their choice and other methods of regulation or control of their fertility.'[123] These rights must be enjoyed while respecting their dignity and integrity as well as ensuring equality and freedom from coercion and violence. Although regional and international human rights instruments have laudable provisions to ensure that the dignity of PWDs is respected in the provision of sexual and reproductive health services,[124] adolescent girls with intellectual and psychosocial disabilities in Africa often face challenges in making decisions about sterilisation and abortion. 'Lack of capacity' is often

119 ibid.

120 ibid.

121 ibid.

122 ibid.

123 UNFPA, 'Frameworks and Policies on Sexual and Reproductive Health Gender, Human Rights and Culture Branch, Technical Division, United Nations Population Fund (UNFPA)' <https://www.unfpa.org/sites/default/files/jahia-events/webdav/site/global/shared/documents/events/2009/policies_frameworks.pdf> accessed 13 January 2024.

124 See CRPD, art 12.

used in laws and in practice as a reasonable justification for violating the rights of adolescent girls with intellectual and psychosocial disabilities.[125]

5.3 *Accountability*

The principle of accountability is crucial in ensuring equal access to SRH services by adolescent girls with disabilities. Accountability is defined as 'the means by which individuals and communities take ownership of their rights and ensure that states, as primary duty bearers, respect, protect and fulfil their international and national obligations'.[126] This principle is important in ensuring the right to access an effective remedy and mechanisms that provide redress to victims of human rights violations.[127] Article 23 of the CRPD requires states to ensure that adolescents with disabilities realise their right to the highest possible standard of physical and mental health.[128] General Comment No. 4 of the CRC provides that to meet the requirements of Article 23 of the CRC, 'States must put a number of measures such as ensuring that health facilities, goods and services are available and accessible to all adolescents with disabilities and that these facilities and services promote their self-reliance and their active participation in the community.'[129] In addition, states must consider the special needs relating to the sexuality of adolescents with disabilities, as well as remove barriers that hinder adolescents with disabilities from realising their rights.[130] Therefore, states should be held accountable for failing to act on their obligations to realise the SRHR, especially access to information and electronic services on contraception for adolescents with disabilities. Both national courts and regional human rights bodies have an important role to play in this regard. They can serve as the watchdogs for government activities in relation to the implementation of the SRHR for adolescents with disabilities in the region. Additionally, civil society groups and national human rights institutions can play a central role in holding states accountable for their

125 Anwuli Irene Ofuani, 'Protecting adolescent girls with intellectual disabilities from involuntary sterilisation in Nigeria: Lessons from the Convention on the Rights of Persons with Disabilities' (2017) 17 African Human Rights Journal 550, 565.

126 UN Special Rapporteur on the Human Rights to Safe Drinking Water and Sanitation, 'Report on the principle of accountability in the context of the realisation of the rights to water and sanitation' <https://www.ohchr.org/sites/default/files/Documents/Issues/Water/AccountabilityInfographics.pdf> accessed 6 April 2024.

127 ibid.

128 CRPD, art 23.

129 CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, CRC/GC/2003/4, para 31.

130 ibid.

failure to meet the SRHR of adolescent girls with disabilities. This can be done through litigation in courts, petitions to national human rights institutions and submitting communications to human rights bodies to address failure on the part of states.

5.4 *Participation*

Participation is described in the WHO International Classification of Functioning, Disability and Health (ICF) as the participation in a life situation which includes, among other things, spheres of learning and applying knowledge, communication, home life, social life and relationships.[131] Meaningful participation in decision-making is recognised as an important issue affecting human health, wellbeing and overall quality of life.[132] Participation in decision-making about one's health is recognised as crucial to achieving the right to health.[133] Furthermore, Article 13 of the African Charter recognises the right to participation of all individuals.[134] Therefore, to allow adolescent girls with disabilities to experience an improved quality of life, they are supposed to participate in decision making that affects their sexual and reproductive health. One way that states can ensure this participation is in the analysis of data to determine the enjoyment of the right to health by citizens.[135] Allowing adolescent girls with disabilities to analyse this information will ensure that data related to them are understood and used in a way that is sensitive to their needs and situation.[136] Article 23 of the CRC is very important, since it calls on states to facilitate the means to enable the participation of PWDs in matters related to their reproductive lives such as deciding the number and spacing of children.

131 Karina Huus, Liezl Schlebusch· Maria Ramaahlo, Alecia Samuels and Ingalill Gimbler Berglund and others, 'Barriers and Facilitators to Participation for Children and Adolescents with Disabilities in Low and Middle-Income Countries: A Scoping Review' (2021) 10 African Journal of Disability 1,1.

132 Anot Golos, Chani Zyger, Yael Lavie-Pitaro and Dana Anaby, 'Improving Participation Among Youth with Disabilities within Their Unique Socio-Cultural Context During COVID-19 Pandemic: Initial Evaluation' (2023) 20 International Journal of Environmental Research and Public Health 1, 1.

133 OHCHR Committee on Economic, Social and Cultural Rights, General Comment 14 The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), E/C.12/2000/4.

134 African Charter, art 3.

135 CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, CRC/GC/2003/4, para 9.

136 ibid.

Notably, Article 23 was inspired by the Standard Rules on Equalisation of Opportunities for Persons with Disabilities, which call for 'the full participation of persons with disabilities in family life …'.[137] This can be achieved through different ways, including ensuring that states realise the right to personal integrity of PWDs and that laws do not discriminate against them with respect to their sexual relationships, marriage and parenthood.

Despite the importance of the principle of participation and the fact that it is recognised as a right in the African Charter, in most African countries, adolescents' girls with disabilities in general are not involved in matters that concern them. Even in the process of enacting laws, most public consultations are not accessible to PWDs in terms of geographical location or sharing of information in accessible formats such as braille. As a result, policies and laws end up not reflecting the needs of PWDs since decisions are made on their behalf by non-disabled people or by a few PWDs. For example, the public consultation process in Zimbabwe in general mostly considers disabilities that are considered 'common' such as visual and hearing impairments. As a result, where accommodations are made for people with such disabilities, those with hearing and visual impairments tend not to benefit.

6 Conclusion and Recommendations

Adolescents, in general, face barriers in accessing SRH services. The situation worsens for female adolescents with disabilities because the challenges they face intersect with many factors such as age, sex, disability, ethnicity, religious or cultural beliefs, as well as geographic location. Regional and international human rights standards are instrumental in advocating for access to SRH services by adolescent girls with disabilities on an equal basis with their counterparts. Despite the presence of such progressive standards, adolescent girls are still left behind because laws, policies and other frameworks do not have regard for the unique features of adolescent girls with disabilities. Societies, health personnel and caregivers also ignore the unique needs of adolescent girls with disabilities, who still face stigma and discrimination despite the 2030 Agenda for Sustainable Development, 'Leaving no one behind!' aspirations.

The following recommendations seek to ensure that adolescent girls with disabilities access sexual and reproductive health services on an equal basis with non-disabled adolescent girls:

137 Standard Operating Rules on the Equalisation of Opportunities for Persons with Disabilities, rule 9.

- States are encouraged to enact or amend sexual and reproductive health laws and policies to align them with aspirations and principles of non-discrimination, human dignity and participation.
- There is a need to incorporate a Human Rights Based Approach to service delivery and in drafting of laws.
- States are required to strengthen the data collection process in a disaggregated form so as to ensure accurate and useful information on the needs for SRHR of adolescent girls with disabilities in the region.
- In line with the substantive equality approach, states must articulate non-legislative measures to advance access to SRH services by adolescent girls with disabilities. These measures may include non-payment for certain services, revamping of buildings and making them friendly for adolescents using wheelchairs, and providing sign language interpreters in health facilities to assist those with hearing impairments.
- The responsible government ministries, departments or agencies in partnership with non-state actors are encouraged to conduct awareness campaigns such as workshops, radio programmes and community outreaches on the rights of PWDs including their SRHR. The awareness raising activities should target health personnel, adolescent girls with disabilities, parents, cultural and religious leaders and non-disabled adolescents.