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01. INTRODUCTION

The United Nations Commission on Human Rights (UNCHR) and the Office of High Commission for Human Rights (OHCHR) argue that human rights are essential to all human beings irrespective of nationality, place of residence, sex, national or ethnic origin, color, religion, language, or any other status, and everybody is entitled to interrelated, interdependent and indivisible human rights without discrimination. These rights also apply to people who are differently abled. The International Classification of Functioning, Disability and Health (ICF) defines disability as a broad term for impairments, activity limitations and participation restrictions, in accordance with the United Nations Convention on the Rights of Persons with Disabilities (CRPD)2 .

The CRPD indicates that people with disabilities include those who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in sexual and reproductive health programmes and policies. The CRPD is a modern human rights treaty with innovative components. It is an instrument that has an explicit social development dimension that reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. Prior to this convention, disability was seen as a fixed bodily condition , thereby silencing the sexuality of those who are differently abled. This fueled stigma and stereotype against people who with disabilities, and reinforced prejudices that equate disability with incompetence, incapacity, impotence, and asexuality

Therefore, the adoption of CRPD in 2006, brought about a paradigm shift in disability policy in the context of understanding that disabled persons are right holders and human rights subjects. The most critical part of the CRPD is Article 1 that states that: “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” The CRPD introduces a new equality concept into international human rights law, which can be categorized as transformative equality. This implies that impairment may not be used as a justification for denial or restrictions of human rights, including sexual and reproductive rights

[1]https://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx
[1]UN General Assembly (2006). Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, A/RES/61/106. Available from: http://www.refworld.org/docid/45f973632.html
[Google Scholar] [1]Samuels E (2006). A “complication of complaints”: untangling disability, race, and gender in William and Ellen Craft’s running a thousand miles from freedom. MELUS. 2006; 31(3):15–47. doi: 10.1093/melus/31.3.15.

02. PURPOSE OF SERVICE MAPPING

The main purpose of the mapping exercise was to give an indication of available SRH services for women with disabilities and gaps therein. As such, the mapping exercise addressed the following questions:

i. Where can SRH services be accessed in Gaborone, Palapye and Francistown?
ii. Are the services available, accessible, and acceptable for PWD and do they allow for participation?
iii. Do duty bearers have the capacity to provide SRH services to PWD?
iv. What is the regulatory framework with regards to SRH services for PWDs?
v. What are the gaps in service provision – if any?

The realization of sexual and reproductive health rights should be embedded in programmes and policies of a country. These programmes include, but are not restricted to: services for family planning; infertility services; maternal and newborn health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections (STIs), including HIV infection, reproductive tract infections, cervical cancer and other gynecological morbidities; promotion of sexual health, including sexuality counseling; and prevention and management of gender-based violence. These rights are expressed and guaranteed by law (in the forms of treaties, customary international law, general principles and other sources of international law) and governments are expected to assume obligations and duties under international law to respect, protect and fulfill human rights of people with disabilities.

It is in this context that the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), through the support of FELM is implementing a project in Gaborone, Palapye and Francistown titled "Advancing Universal Access to SRHR Services for Women with Disability in Botswana". Through implementation of disability focused interventions, evidence reaching the organization suggests that most health facilities in Botswana are designed with no consideration for the specific needs of People with Disabilities (PWDs). As a result, accessibility to SRH service such as prenatal and postnatal care, services and information related to HIV/AIDS, family planning among others often do not take into consideration the different categories of impairment of PWDS. Most of these gaps are the result of the absence of a comprehensive policy and legislative framework for PWDs.

The project is specifically aimed at:
i. Increasing knowledge on SRHR needs, discrimination and gender based violence among and affecting women with disability in Botswana;
ii. Increasing knowledge on rights and in particular, rights of PWD particularly access to SRH services by women in the reproductive ages of 15 – 49 years;
iii. Improving public knowledge on disability in Botswana; and
iv. Documenting program evidence for targeted advocacy SRHR and other programming for PWD.

It is against this background that BONELA conducted a mapping exercise of SRH services across the three implementation sites to generate evidence on the availability of SRH services for women with disabilities in the reproductive age (15-49 years).

03. APPROACH AND METHODOLOGY

The study was a descriptive cross-sectional survey conducted in December 2020 in three selected districts (Gaborone, Palapye and Francistown) of Botswana using a qualitative approach. Data collection tools were administered to collect data from PWDs, health service providers and community leaders. In addition, the SRH mapping exercise was also informed by a comprehensive desk review of the relevant policy documents and secondary materials (guidelines, plans and reports).

04. FINDINGS

4.1 Availability of SRH services at the surveyed health facilities

The SRH services were mapped at 28 health facilities (9 in Gaborone, 9 in Palapye and 10 in Francistown). The facilities were assessed for disability related health facility, health service provider and SRH program characteristics. Overall, Francistown health facilities exhibited characteristics that were friendlier to people with disabilities compared to those in Palapye and Gaborone as shown in table 1 below.

Table 1: SRH related characteristics of health facilities surveyed

Variable	Number (%) of facilities in Gaborone (n=9)	Number (%) of facilities in Palapye (n=9)	Number (%) of facilities in Francistown (n=10)
Health Facility Characteristics			
Is the health facility located constructed to cater for people with disabilities?	0 (0.0)	6 (66.7)	10 (100)
Is the facility open during hours that are convenient for people with disabilities?	0 (0.0)	6 (66.7)	9 (90.0)
Are there specific health facility times or spaces set aside for people with disabilities?	0 (0.0)	2 (22.2)	6 (60.0)
Is there a separate, discreet, entrance for people with disabilities to ensure their privacy?	1 (11.1)	1 (11.1)	5 (50.0)
Do counseling and treatment rooms allow for privacy (both visual and auditory)?	8 (88.9)	4 (44.4)	8 (80.0)
Is there a Code of Conduct in place for staff at the health facility in the context of people with disabilities?	0 (0.0)	5 (55.6)	7 (70.0)
Is there a transparent, confidential mechanism for people with disabilities to submit complaints or feedback about SRHR services at the facility?	1 (11.1)	3 (33.3)	6 (60.0)

The health facilities surveyed in Gaborone had the least positive characteristics. For instance, according to the key informants, all health facilities in Gaborone were not constructed to cater for PWDs and were not opening during hours convenient for PWDs, such during weekends

Furthermore, the facilities surveyed did not have specific spaces set aside for PWDs and did not have a Code of Conduct in place for staff at the health facility in the context of PWDs.

The study participants in all the three participating districts were also asked about the availability of SRH services. Most of the PWDs across all the three participating districts commended the health service providers for short waiting time, good quality of counseling services, privacy, confidentiality and explicit provision of SRH messages. Most of the PWDs expressed respect for privacy and confidentiality while providing SRH services to adolescents. They also indicated that their needs were completely satisfied. The PWDs reported to have received the services they sought at the health facilities in the three participating districts. Some of the services include STI screening, STI treatment, HIV testing and ARV collection. Some PWD clients also indicated that they had received fertility awareness, antenatal counseling, and postnatal care services.

However, some PWDs across all the health facilities mentioned that although SRH services were available at the facilities, they are often under-utilized due to lack of awareness by PWDs.
In-depth interviews with PWDs showed that the major sources of information on SRH services provided were radios, television and social media. However, the unavailability of braille was cited a major barrier to access to SRH services.

4.2 Capacity to Provide SRH services to PWD

The mapping exercise also assessed the capacity of health service care workers in providing services to people with disabilities. As shown in table 2 below, the study ascertained that staff in Gaborone and Francistown demonstrated more respect when interacting with people with disabilities and ensured people with disabilities' privacy and confidentiality compared to service providers in Palapye.

Table 2: Capacity of health service providers in the health facilities surveyed

Health Service Provider Characteristics	Number (%) of facilities in Gaborone (n=9)	Number (%) of facilities in Palapye (n=9)	Number (%) of facilities in Francistown (n=10)
Have providers been trained to provide people with disability-friendly services?	0 (0.0)	6 (66.7)	7 (70.0)
Have all staff been oriented to providing confidential people with disabilities? (Probe for receptionist, security guards, cleaners, etc.)	0 (0.0)	4 (44.4)	6 (60.0)
Do the staff demonstrate respect when interacting with people with disabilities?	9 (100.0)	5 (55.6)	8 (80.0)
Do the providers ensure people with disabilities' privacy and confidentiality?	9 (100.0)	3 (33.3)	9 (90.0)
Do the providers set aside sufficient time for client-provider interaction in the context of SRH among people with disabilities?	1 (11.1)	4 (44.4)	7 (70.0)

Although the health service providers in the surveyed Gaborone health facilities showed respect and ensured confidentiality, most of them (including receptionists, security guards and cleaners) had neither been trained to provide people with disability-friendly services including respect for their confidentiality as cited by the key informants interviewed at the facilities. However, a relatively higher number of health care workers in Francistown and Palapye had been trained and oriented on service provision for PWDs. The respondents felt that there is need for continuous in-service training and documentation of services provided to PWDs. They further indicated that continuous training would enable them to provide SRH services to PWDs without any prejudice or stigma. The health service providers also lamented being over-worked by other health care services while providing SRH services.

The mapping exercise also established availability of a wide range of SRHR services (FP, STI treatment and prevention, condom provision, HIV counseling and testing, ante- and post-natal care, delivery care) across all surveyed facilities in all the three districts as shown in table 3 below. However, very few facilities had written facility guidelines for providing services to people with disabilities. The key informants were concerned with the lack of written detailed specific guidelines for provision of SRHR services to PWD in some facilities. They argued that availability of standardized guidelines in all facilities eliminates variations in clinical practice, and decreases preventable mistakes and adverse events.

According to the key informants, SRH educational materials, posters or guidelines were on site, and designed to reach people with disabilities. Health service providers interviewed in all the three participating districts felt that all the required information by PWDs on SRH services are made available during ongoing campaigns organized by District Health Management Teams (DHMTs) and civil society organisations (such as BONELA and DPOs). While most health facilities in Gaborone and Francistown have referral mechanisms in place for medical emergencies for people with disabilities, only two of the nine facilities surveyed in Palapye are reported have the referral system.

Table 3: SRH Programmes for People with Disabilities in the districts surveyed

SRH Programmes for PWDs	Number (%) of facilities in Gaborone (n=9)	Number (%) of facilities in Palapye (n=9)	Number (%) of facilities in Francistown (n=10)
Do people with disabilities play a role in the operation of the health facility?	0 (0.0)	3 (33.3)	7 (70.0)
Are people with disabilities involved in monitoring the quality of SRHR service provision?	3(33.3)	2 (22.2)	3 (30.0)
Is a wide range of SRHR services available? (FP, STI treatment and prevention, HIV counseling and testing, ante- and post-natal care, delivery care)	8 (88.9)	8 (88.9)	8 (80.0)
Are there written guidelines for providing services to people with disabilities?	0 (0.0)	2 (22.2)	5 (50.0)
Are condoms available to people with disabilities?	9 (100.0)	7 (77.8)	6 (60.0)
Are there SRH educational materials, posters or guidelines on site, which are designed to reach people with disabilities?	8 (88.9)	2 (22.2)	10 (100.0)
Are referral mechanisms in place for medical emergencies for people with disabilities?	8 (88.9)	2 (22.2)	8 (80.0)
Are people with disabilities-specific indicators monitored on a regular basis? (e.g. number of people with disabilities, nature of disability, disaggregated by age and sex)	0 (100.0)	1 (11.1)	8 (80.0)

The health facilities in Gaborone did not have disability-specific indicators (e.g. number of people with disabilities, nature of disability, disaggregated by age and sex) that are monitored on a regular basis. Furthermore, the key informants further indicated that the surveyed health facilities in Gaborone did not engage PWDs in development of SRH related programmes and operation of the health facilities.

4.3 Barriers to Access to SRH services

The SRH services mapping assessed potential factors that can negatively impact on the accessibility and quality of services in the three participating districts. The assessment documented the obstacles that the community leaders perceive to be limiting health (specifically SRHR services) seeking behavior by PWDs. The in-depth interviews with community leaders and civil society organizations reveal that the health care providers' efforts to provide PWDs with SRH services are often hindered by stigma from the community, lack of progressive policies and some family members that limit PWDs' ability to request or access the SRH services. This is demonstrated by the following statements from the key respondents:

"Most abled persons do not want to be associated with a disabled person even if they have a relationship. This makes them prone to STIs and other related conditions. Stigma is also there in the community". Community leader in Francistown.

"The community does not know much about people with disabilities. This causes stigma and discrimination". Community leader in Gaborone.

"People in the community discriminate because they lack knowledge". Community leader in Palapye.

"Stigma is the number one priority. Most disabled people feel offended when asked about their sexuality and secondly, structure of the facility does not allow easy access and confidentiality" Community leader in Francistown.

Furthermore, the community members interviewed said that PWDs do not have suitable means through which to give feedback on services provided. This is coupled with the fact that they are less involved in suggesting ideas regarding the services that they would like to have provided to them. These made the respondents feel that the SRH needs of PWDs might not be met in several facilities.

"There is no transparent and confidential mechanism for PWDs to submit complaints or feedback about SRH services at the facility, but the adolescents receive results or feedback from the services delivered". Civil society organization member.

Some respondents (PWDs) also reported instances of breaches of confidentiality and failures of healthcare workers to provide reasonable accommodation, including provision of interpreters for hearing impaired individuals. The inability of health service providers to avail interpreters for the deaf leads to low uptake of services and lack of disability friendly information on issues of sexuality and reproductive health. Furthermore, some civil society organizations in the participating districts cited the lack of sufficient policies and a conducive legal framework to undermine the national obligation to maintain a system of care for people with disabilities. According to community respondents, PWDs are at risk of HIV due to lack of societal awareness of their needs, violence and sexual abuse, discrimination in health-care settings and low awareness and risk perception about HIV. A review of the national response has also revealed that people with mental and physical disabilities may have challenges accessing healthcare, education and employment, leading to impoverishment and creating further vulnerability to HIV, TB and overall poor health outcomes. These are critical barriers to uptake of health services that need to be addressed.

05. DISCUSSION

The main finding from the SRH mapping exercise is that most of the health facilities have SRH services available for PWDs. However, in the context of health facility characteristics, Francistown and Palapye seem to be doing well in availing SRH services to help PWD access them compared to Gaborone facilities surveyed. In most Gaborone health facilities surveyed, SRH service provision is designed for the general population without specific attention to the needs of PWDs. Some SRH educational material and posters are designed to reach people with disabilities, and are disseminated to PWDs at the health facilities or during ongoing campaigns organized by District Health Management Teams and civil society organisations. However, some facilities do not have standardized guidelines specifically for improving effectiveness and quality of care to PWDs.

The study data further reveals that delivery of SRH services is limited due to stigma, discrimination, lack of written guidelines for the provision of SRH services to PWD and lack of a comprehensive legal framework that addresses the needs of people with disabilities. There is a need to address social protection issues such as inclusive access to education through the use of braille, sign language interpretation and addressing sexual abuse among PWD. Further, due to the limited information on HIV prevalence amongst people with disabilities, it is critical to conduct community-based information and awareness-raising campaigns to promote greater tolerance, respect and understanding of persons with disabilities in the context of HIV. It is also important to promote the inclusion of people with all types of disabilities in community decision-making processes and at all stages of the program cycle, ensuring age and gender diversity. The country should also fast track the finalization of the legislative framework for people with disabilities and distribution of standardized guidelines to all health facilities.

The revised Policy on Disability was tabled in Parliament in August 2016 but has not yet been enacted. When passed by parliament, the policy will set forth obligations and duties of various stakeholders, and establishes a National Coordinating Committee on disability to oversee strategic plans across various Ministries. The committee will monitor implementation of the National Policy on Care for People with Disabilities and programmes developed under its framework. The legislative framework takes into account the educational, health and other programmes. The committee will address monitoring and evaluation system for disability, with special attention on disabilities-specific indicators (e.g. number of people with disabilities, nature of disability, disaggregated by age and sex) which will be monitored on a regular basis.

The SRH mapping exercise did not find geographical accessibility of SRH services to negatively affect access by PWDs. However, the challenge was associated with access to wheel chairs and availability of braille translation. The limited time to interact with PWDs during SRH service provision cited by service providers constitutes to be a significant setback to SRH services accessibility by PWDs. This is associated with the competing and varying responsibilities of health care workers due to the shortage of SRH service providers

A safe and supportive environment for PWDs' health agenda, as highlighted in the CRPD needs to be implemented and followed up in all community settings that offer SRH services. The SRH community views on improving the quality of the services for PWDs include removing several barriers mostly posed by community members, family members, and policy environment. These barriers play a role in provision of quality SRH services for PWDs. This calls for policymakers, activists, and the community to formulate methodologies to ensure that the SRH services accessibility, availability, as well as the quality of services provided are considered while designing health services provision to ensure that the "no one left behind" principle is applied to achieve Sustainable Development Goal (SDG) 3

05. CONCLUSION

The study has demonstrated that SRH services are available, accessible and utilized by PWDs. However, due to social norms, taboos and lack of robust policy environment, PWDs will continue to experience poor sexual and reproductive health rights outcomes. The lack of SRH policies for PWDs often leads to stigmatization and marginalization of PWDs from society, sexual abuse and a high unmet need for contraception. It is therefore critical for PWDs to universally access comprehensive sexual and reproductive health services, information and have their rights fulfilled. This calls for renewed commitment by policy makers to address gaps and emerging issues for sexual and reproductive health and rights for PWDs. It is also an issue of social justice to empower PWDs and promote gender equality in pursuance of the SDGs.

Sexual and reproductive health rights policies are vital to empowering PWDs for fulfillment of and enjoyment of sexual and reproductive health and rights. Whilst the rhetoric has been on the inalienable rights of all, in some communities, the reality on the ground has been characterized by the violation of rights; PWDs are one such community. In Botswana, sexual activity is one of the leading modes of transmission of STIs, including HIV. The main concerns for PWDs are not just HIV or sexually transmitted infections, but other sexual reproductive health issues.