2024
SYNTHESIS POLICY BRIEF
28

Intersectional barriers:

SRHR and family planning access for women and girls with disabilities in Cameroon, Zambia, Sierra Leone, and Uganda

B. Alieu, I. Chanda, R. Dey, W. Elbers, L. Honders, A. Ibrahim, C. Jaff, T. Mtonga and V. Ngalim

Abstract

This study examines the barriers that prevent women and girls with disabilities in Cameroon, Uganda, Zambia, and Sierra Leone from accessing Sexual and Reproductive Health and Rights (SRHR) services, and family planning services in particular. Utilising an intersectional approach, it highlights significant challenges in both the broader environment, individual identity traits, and the family. In the wider environment, major obstacles include stigma and religious beliefs in healthcare and social settings, inadequate training of healthcare professionals, and ineffective communication strategies by healthcare centres. On the individual level, factors such as financial dependence, type of impairment, geographical location, and education level significantly impact access to SRHR services. The family acts as a mediator between environmental challenges and identity characteristics, either supporting or constraining the ability of women to navigate these challenges. The study provides eight key policy recommendations to address these multifaceted challenges.

'Breaking down Barriers' was initiated by Liliane Foundation to contribute to more effective and evidence-based policies and programmes in the field of disability inclusive development. It does so by bringing together civil society organisations and researchers from the Netherlands, Cameroon, Sierra Leone and Zambia.

Introduction

SRHR encompasses the physical, emotional, mental, and social well-being related to the reproductive system, extending beyond the mere absence of disease or infirmity. Central to SRHR is the empowerment of individuals to make informed choices about their sexual and reproductive lives. On the one hand, this ensures protection against diseases, unwanted pregnancies, and sexual and gender-based violence, while on the other hand, it supports access to skilled healthcare providers. Beyond the absence of reproductive or sexual illnesses, it also entails the full enjoyment and well-being of sexual health. This comprehensive understanding of SRHR is particularly crucial for individuals with disabilities, as emphasised by Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which mandates that governments provide accessible and inclusive SRHR services on an equal basis to those without disabilities.

Despite signing international treaties and enacting national laws to protect the rights of persons with disabilities, countries in Sub-Saharan Africa face significant challenges in providing equitable access to SRHR services for women and girls with disabilities. For instance, Sierra Leone's Persons with Disability Act and the Free Healthcare Initiative aim to reduce maternal and child mortality by offering free access to essential healthcare services, yet women and girls with disabilities still encounter substantial barriers. Similarly, in Uganda, national policy guidelines lack specific provisions for individuals with disabilities, leading to significant disparities in accessing SRHR services. Furthermore, in Cameroon and Zambia, policies that appear effective on paper often fail to deliver in practice, leaving women and girls with disabilities without access to essential SRHR services.

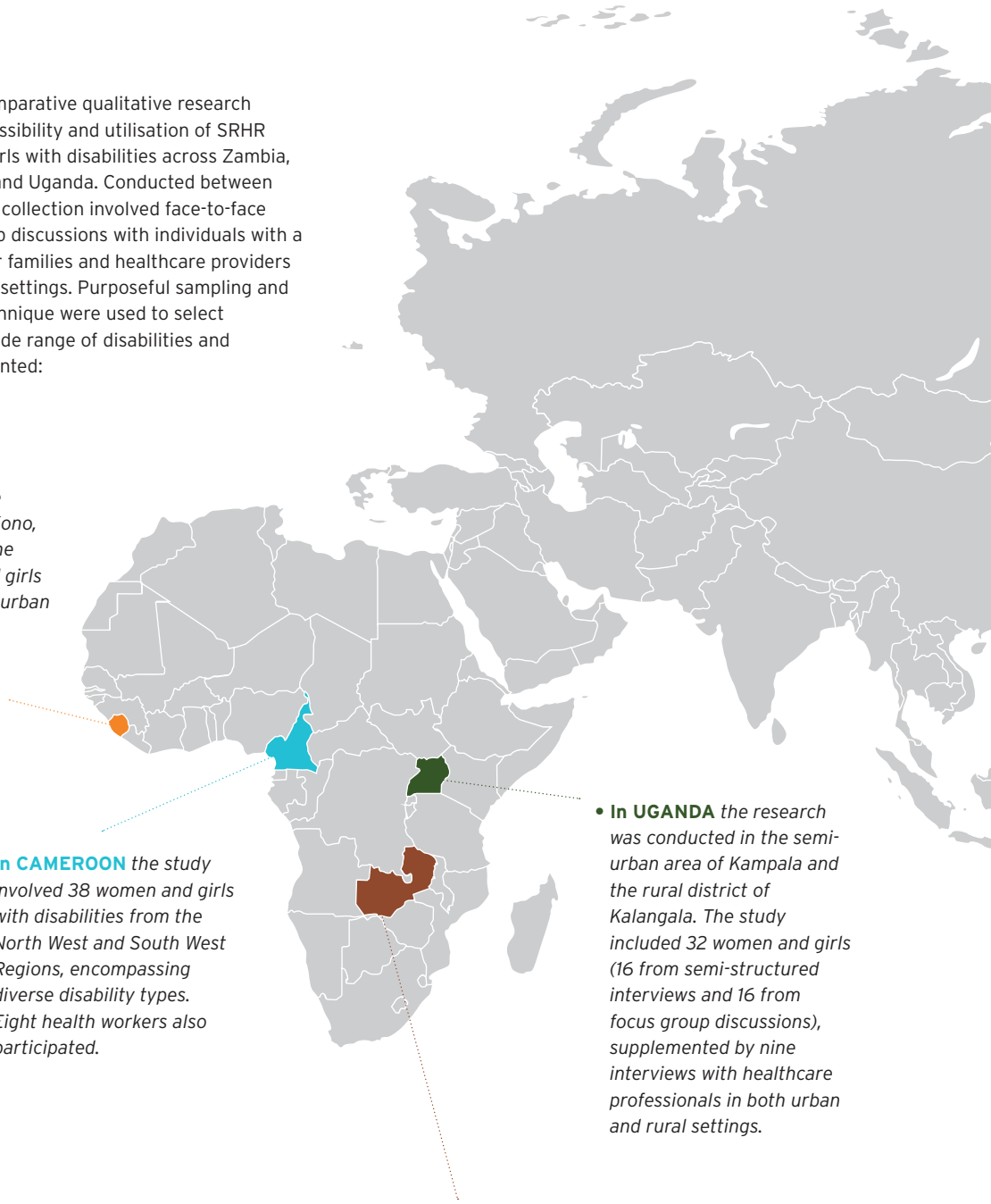
Shortages of accessible SRHR services for many women and girls with disabilities perpetuates gender and disability inequalities, denying them the autonomy and dignity to make informed decisions about their reproductive health. This lack of access contributes to unwanted pregnancies and sexually transmitted infections, resulting in poorer health outcomes and increased mortality rates. Additionally, it hinders overall public health goals and the socio-economic development of communities by excluding a significant portion (around 15% on global average) of the population from essential healthcare services.

This study examines the ability of women and girls with disabilities to access and utilise SRHR services, particularly family planning services, from an intersectional perspective. Family planning involves providing individuals and couples with the resources, education, and services needed to decide freely and responsibly the number and timing of their children, often through access to contraception and reproductive health care. An intersectional lens acknowledges and explores how various social identities, such as impairment type and level of education, intersect and interact to enable or constrain access to SRHR services. By considering the interplay of multiple identities within the broader environment, this study aims to answer the question: How do environmental barriers and intersecting identities of women with disabilities in Zambia, Sierra Leone, Uganda & Cameroon affect their ability to access and utilise SRHR services?

Portrait of a mother and a father with their children. PHOTO: RONNIE DANKELMAN

METHODOLOGY

This study employed a comparative qualitative research design to explore the accessibility and utilisation of SRHR services for women and girls with disabilities across Zambia, Cameroon, Sierra Leone, and Uganda. Conducted between April and June 2023, data collection involved face-to-face interviews and focus group discussions with individuals with a variety of disabilities, their families and healthcare providers in diverse urban and rural settings. Purposeful sampling and the snowball sampling technique were used to select participants, ensuring a wide range of disabilities and perspectives were represented:



- **In SIERRA LEONE** *semi-structured interviews were conducted in Bo, Makeni, Kono, and Freetown to capture the experiences of women and girls with disabilities from both urban and rural areas. The study involved 40 participants, including 24 women with disabilities, eight health workers, four caregivers, and four officials from the Ministry of Health.*

- **In CAMEROON** *the study involved 38 women and girls with disabilities from the North West and South West Regions, encompassing diverse disability types. Eight health workers also participated.*

- **In UGANDA** *the research was conducted in the semi-urban area of Kampala and the rural district of Kalangala. The study included 32 women and girls (16 from semi-structured interviews and 16 from focus group discussions), supplemented by nine interviews with healthcare professionals in both urban and rural settings.*

- **In ZAMBIA** *semi-structured interviews were held in Kaoma, Kafue, and Choma with a total of 30 participants, consisting of 22 women with various disabilities and eight health workers.*

Data analysis across all countries utilised inductive and deductive coding to capture the rich complexities of participants' responses. Key themes such as financial autonomy, education level, accessibility of infrastructure, family support, and the intersectionality of identities emerged from the coding process. These themes formed the basis for the study's findings and policy recommendations, highlighting the barriers and challenges faced by women with disabilities in accessing SRHR services.

FINDINGS

The study found that access to SRHR services and family planning for women and girls with disabilities is shaped by a blend of three intersecting factors: (1) environmental barriers, (2) individual identity characteristics, and (3) family dynamics which act as a crucial mediator between individual women and girls and the environmental factors shaping SRHR access.

Young girl is sitting on a bench with two healthcare workers. PHOTO: FRANCISCAN ELIZABETHAN SISTERS

Environmental barriers

Women and girls with disabilities in Cameroon, Zambia, Uganda, and Sierra Leone face significant and strikingly similar environmental barriers that hinder their access to SRHR services. The main barriers emerging from the research are 1) religious beliefs and stigma, 2) inadequate training among healthcare professionals, and 3) ineffective communication and information dissemination strategies by health centres. These barriers reinforce each other and, collectively, constrain access to SRHR services.

Stigma and societal attitudes

In all four countries that were studied, it was found that women and girls with disabilities face multiple forms of stigma within healthcare settings. Stigma refers to the negative attitudes, stereotypes, and discriminatory behaviours they face when accessing family planning services. This manifests in various forms, such as dismissive treatment, insufficient accommodation for the specific needs of women and girls with disabilities, misguided assumptions about their sexual and reproductive rights, and significant barriers to accessing quality care. In all four countries healthcare providers often exhibit discriminatory behaviours, such as using derogatory language or refusing SRHR services. This societal stigma can deeply impact women's self-esteem and discourage them from seeking necessary care. Additionally, societal stigma contributes to self-stigma, where girls and women with disabilities internalise negative societal attitudes and begin to believe they are unworthy of quality SRHR care or that these sets of rights do not apply to them. This self-stigma further diminishes their willingness to seek SRHR services, perpetuating poor health outcomes. The combined effect of societal and self-stigma significantly undermines the quality of healthcare provided to and received by women and girls with disabilities, leading to widespread inequities in SRHR access.

Religious beliefs play a significant role in shaping attitudes and access to family planning services for girls and women with disabilities. In all four countries, certain religious perspectives within both Christianity and Islam were found to promote particular views on sexuality and contraception, leading to the stigmatisation of these services. As a result, these beliefs limit access to family planning by discouraging contraception use and restricting open discussions about sexual health. For instance, in rural Zambia's Kaoma District, societal norms influenced by religious beliefs discourage modern contraceptive practices, prompting women with disabilities to rely on traditional methods, such as the use of marijuana seeds and the wearing of beads around the waist during sexual intercourse. Similarly, in Sierra Leone, adherence to Islamic traditions poses cultural barriers to accessing SRHR services, perceived as conflicting with religious teachings. Conversely, communities practising traditional religions show varying degrees of acceptance of family planning.

Training gaps among healthcare professionals

Despite legal safeguards guaranteeing equal healthcare access, healthcare providers in Cameroon, Zambia, Uganda and Sierra Leone often lack adequate training on disability rights and etiquettes and SRHR. Many healthcare professionals are ill-prepared to meet the diverse needs of patients with a disability, whether through a lack of accommodations in communication such as sign language interpreters, understanding of mobility challenges, or appropriate accommodations for intellectual

Young woman is learning how to sew. PHOTO: ST. JOSEPH'S INCLUSIVE MODEL SCHOOL

disabilities. This contributes to substandard care and potential misdiagnoses. It also limits the ability of healthcare providers to offer accurate information and appropriate support, which affects women and girls' ability to make informed decisions about their sexual and reproductive health. Finally, with healthcare providers reproducing prevailing societal stigma towards disability, it can foster stigmatisation and discrimination, making women and girls with disabilities hesitant to seek care.

Communication and information dissemination

Effective and accessible information dissemination is critical for enabling women with disabilities to access SRHR services. However, across all four countries, healthcare centres frequently employ inadequate communication methods and fail to disseminate information in accessible formats, particularly in rural areas. This issue is starkly evident in Zambia, where widespread unawareness of family planning services among women with disabilities persists due to ineffective communication strategies. In many instances, healthcare centres lack essential tools such as braille materials, sign language interpreters, or easy-to-understand information, further complicating access for women with disabilities. This problem is typically worse in rural settings where healthcare access is already limited, resulting in low awareness of SRHR rights and services among women with disabilities and, consequently, poorer health outcomes.

Individual identity characteristics

The study findings from Sierra Leone, Uganda, Cameroon, and Zambia collectively underscore how individual identity characteristics significantly influence access to SRHR services, particularly for women and girls with disabilities. In each country, the same four individual characteristics are most influential in shaping personal experiences. These are: 1) financial dependence, 2) impairment type, 3) geographical location and 4) level of education.

Financial Dependence

Financial autonomy emerged as a critical determinant of access to SRHR services in all four countries. Women who are financially independent often have the means to seek out and afford services, whether through private healthcare providers or by covering associated costs such as transportation to healthcare facilities that provide services and care for free, as seen in the case of Cameroon. However, the reality for many women and girls with disabilities contrasts sharply, as financial constraints frequently render even supposedly free services inaccessible, as manifested in the case of Sierra Leone. In many instances documented across various countries, women have been charged informal fees or faced shortages of government-supplied contraceptives despite policies mandating free access. This discrepancy disproportionately affects economically disadvantaged women with disabilities, reinforcing the need for clearer implementation of policies that ensure true financial accessibility to SRHR services.

Conversely, the ability to pay out of pocket for health services also intersects with the type of disability. For example, in Sierra Leone, people with polio-related physical disabilities and those who are visually impaired tend to be more educated and therefore more likely to be employed in the formal sector. Hence, these women are better financially situated than the hearing and intellectually impaired.

Impairment Type

In each country, the accessibility of SRHR services is significantly influenced by the type of impairment, each presenting distinct challenges. Women with visual impairments or mobility limitations face physical obstacles such as inaccessible healthcare facilities and inadequate transportation options. Similarly, those with hearing impairments encounter communication barriers exacerbated by the absence of trained sign language interpreters at healthcare centres. These impairments often intersect with other identity characteristics, thereby compounding challenges. For example, women with intellectual disabilities often struggle to comprehend SRHR information or advocate for their rights due to societal misconceptions about their capabilities. These intersections underscore the critical need for healthcare services tailored to diverse impairment types, ensuring inclusivity and accessibility across service delivery.

Certain impairments, such as visual or hearing impairments, can limit access to SRHR information and education materials. Inaccessible formats or the absence of communication aids like braille materials or sign language interpreters at healthcare facilities exclude women with disabilities from receiving comprehensive information about family planning, contraception options, and sexual health.

Examples can be found in different contexts. In Uganda, for instance, women with visual impairments or mobility limitations encounter physical barriers like inaccessible healthcare facilities and inadequate transport options. Similarly, in Sierra Leone, those with hearing impairments face communication barriers due to the absence of trained sign language interpreters at healthcare centres. These challenges are compounded by other identity characteristics, such as intellectual disabilities, which hinder understanding of SRHR information and advocacy for rights, as observed in Cameroon. To address these intersectional challenges effectively, tailored healthcare services must accommodate diverse impairment types, thereby promoting inclusivity and accessibility in the delivery of SRHR services.

The attitude of healthcare providers towards women with disabilities vary based on the type of impairment they have. Providers often demonstrate greater understanding and accommodation towards women with visible physical disabilities compared to those with intellectual disabilities. Negative attitudes or inadequate training in disability awareness can lead to poor communication, misunderstandings of needs, and insufficient provision of SRHR information and family planning services.

Geographical location

Geographical location profoundly shapes the accessibility of SRHR services for women and girls with disabilities across the countries examined. Disparities between urban and rural areas underscore varying levels of accessibility and the challenges faced by women with disabilities in these settings. In urban centres such as Lusaka in Zambia, Douala and Yaoundé in Cameroon, and various cities in Uganda and Sierra Leone, women and girls with disabilities generally enjoy better access to SRH services. Urban areas typically boast a higher concentration of healthcare facilities, specialised clinics, and trained healthcare professionals. For instance, Lusaka hosts multiple specialized clinics offering services like family planning and antenatal care with accommodations for different impairment types.

Conversely, rural areas present significant challenges for women and girls with disabilities seeking SRHR services in these countries. Rural Zambia, for instance, experiences substantial gaps in healthcare infrastructure outside major cities like Lusaka. Remote regions often lack accessible healthcare facilities, face shortages of medical supplies and trained personnel, and struggle to provide essential SRHR services such as contraception and maternal healthcare. Similarly, rural districts in Uganda, like Karamoja and Busoga, contend with limited healthcare infrastructure and inadequate transportation networks, complicating access to specialised care for mobility limitations or sensory impairments. In Sierra Leone, rural areas beyond Freetown encounter similar barriers due to sparse healthcare facilities and a lack of disability-tailored services, exacerbated by geographical isolation and poor road infrastructure.

Young woman on her way to the market. PHOTO: RONNIE DANKELMAN

Furthermore, rural communities in all four countries appeared to uphold traditional beliefs regarding sexuality and reproductive health, which can conflict with modern SRHR services and pose additional barriers for women with disabilities. Cultural norms can stigmatise disabilities as punishments or curses, leading to exclusion from community activities and limiting access to healthcare services. These cultural barriers contribute to the reluctance of women with disabilities to seek SRHR information and services, influencing their health-seeking behaviours significantly.

Level of Education

Education emerges as a powerful tool for empowerment among women with disabilities, equipping them with essential knowledge about SRHR and family planning methods. Educated women demonstrate a higher awareness of available SRHR options, enabling them to navigate healthcare systems more effectively and assert their rights confidently. Conversely, lower levels of education correlate with misinformation and limited understanding of SRHR, leading to reliance on traditional methods and reluctance to seek modern family planning services. Inaccurate information about, for example, contraception from peers can shape beliefs and practices among less educated women, affecting their use of sexual and reproductive health services. Educational interventions are crucial in dispelling myths, promoting comprehensive understanding of SRH options, and empowering women with disabilities to make informed decisions about their reproductive health.

For example, in Cameroon, educated women demonstrate higher awareness of available family planning methods, enabling them to navigate healthcare systems confidently and assert their rights. The findings from Uganda indicate that the type of education can be as significant as the level of education itself. Specifically, vocational training has been shown to empower women by providing them with skills necessary to start businesses, thereby fostering financial independence.

Intersectional Dynamics

The findings from Zambia, Cameroon, Uganda, and Sierra Leone highlight how multiple identity characteristics intersect and reinforce barriers to accessing SRHR services. The following interactions stand out from the analysis:

1. **FINANCIAL DEPENDENCE AND GEOGRAPHICAL LOCATION:** Women with disabilities residing in rural areas encounter profound barriers to SRHR services due to their financial dependence and the limitations of local infrastructure. In Zambia, for instance, economic constraints force these women to rely heavily on informal support networks, hindering their ability to afford transportation to healthcare facilities. Similarly, in Cameroon, inadequate infrastructure exacerbates financial dependence, making SRHR services inaccessible. Sierra Leone further illustrates this challenge, where remote locations compound economic barriers, while in Uganda, rural women face economic hardships, relying on informal networks for healthcare expenses.

2. **TYPE OF IMPAIRMENT AND GEOGRAPHICAL LOCATION:** Geographical location significantly impacts women with disabilities, particularly those with physical or sensory impairments. The research in Zambia highlights how physical barriers in remote rural areas, including poor road conditions and inaccessible healthcare facilities, restrict access. Cameroon echoes this situation, emphasising the isolation of women with sensory impairments in remote settings due to inadequate transportation and communication aids. Sierra Leone underscores the compounded challenges faced by women with disabilities in remote areas, highlighting that inadequate healthcare infrastructure hinders access to people with mobility and sensory impairments. Similarly, the findings from Uganda depict the struggles of rural women with disabilities, emphasising the lack of infrastructure and specialised services that exacerbate barriers to SRH services.

3. **TYPE OF IMPAIRMENT AND LEVEL OF EDUCATION:** The intersection of impairment type and educational attainment significantly influences access to SRHR services for women with disabilities. Findings from Zambia and Cameroon reveal disparities in educational opportunities for women with intellectual disabilities or severe impairments, limiting their understanding of SRHR information. Conversely, the research in Uganda exemplifies how formal education can enable women with disabilities to advocate for their SRHR needs effectively. Urban settings in Zambia, Cameroon, and Uganda offer better economic opportunities and autonomy, contrasting with rural areas where women with disabilities face heightened economic challenges and rely on informal support networks for SRHR services.

4. **LEVEL OF EDUCATION AND FINANCIAL DEPENDENCE:** Education plays a pivotal role in alleviating barriers to SRHR services for women with disabilities by enhancing their financial independence and ability to advocate for their needs. In Uganda, educated women with disabilities demonstrate improved access to SRHR services through economic empowerment gained from education. Zambia and Cameroon underscore this relationship, showing how education enables women to overcome financial constraints and navigate healthcare systems effectively.

Young women gathering with friends and family. PHOTO: RONNIE DANKELMAN

Family Involvement

Finally, the family emerged as a crucial mediator between individual women and girls and the environmental factors shaping SRHR and family planning access. Compared to women without disabilities, women and girls with disabilities tend to be more dependent on their families for accessing SRHR services. Families often serve as the primary support system and can significantly influence health-seeking behaviours and decisions. In many cases, family members assist in navigating healthcare systems, provide emotional and financial support, and help in advocating for the needs of women with disabilities.

Families can act as crucial enablers, providing emotional, financial, and logistical support that enables women and girls to access SRHR and family planning services. Supportive family environments can empower individuals to navigate and overcome societal and religious constraints. In addition, they play a vital role in translating SRHR needs to healthcare providers. The findings from Uganda, for example, show that open communication within families can facilitate a better understanding of individual requirements and preferences. However, misconceptions and stigmatising attitudes within families can also pose barriers to SRHR access. Financial concerns regarding the cost of family planning services such as contraception play a role in some families. Additionally, some families hold beliefs that women with (intellectual) disabilities are unsuitable for motherhood. Finally, religious convictions rejecting the notion of birth control also influence family members.

Conclusions

This study reveals a complex, yet quite similar, web of barriers that women and girls with disabilities in Cameroon, Sierra Leone, Zambia and Uganda encounter when accessing SRHR, and specifically family planning services. These barriers span environmental and personal identity dimensions, while family dynamics play an important mediating role in reinforcing and overcoming barriers.

At the environmental level, religious beliefs, stigma, inadequate training among healthcare professionals, and ineffective communication strategies collectively obstruct access to SRHR services for women with disabilities. Stigma within healthcare settings remains pervasive across Cameroon, Zambia, Sierra Leone, and Uganda, where discriminatory attitudes and behaviours among healthcare providers deter women with disabilities from seeking essential care. Religious beliefs further compound these challenges, influencing societal norms that restrict access to modern contraceptives and family planning methods, particularly in rural areas. The inadequacy of disability sensitivity training among healthcare professionals exacerbates these barriers, contributing to substandard care and reinforcing existing disparities in SRHR service provision. Effective communication and information dissemination are critical yet frequently compromised, particularly in rural settings, perpetuating low awareness and understanding of SRHR among women with disabilities.

At the individual identity level, the intersection of financial dependence, impairment type, geographical location, and level of education significantly shape women's experiences in accessing SRHR services. Financial autonomy emerges as a pivotal factor, enabling women with disabilities to overcome economic barriers and seek SRHR services independently. However, economic disparities persist, with many women facing informal fees or shortages of contraceptives despite policies mandating free access. The type of impairment further influences accessibility, with physical barriers in rural areas limiting mobility and exacerbating isolation for women with disabilities. Geographical location magnifies these challenges, as rural areas consistently lack adequate healthcare infrastructure and accessible services compared to urban centres. Moreover, disparities in educational attainment affect women's ability to navigate healthcare systems and advocate for their SRHR needs effectively, underscoring the critical role of education in empowering women with disabilities.

The findings underscore how these barriers intersect and reinforce each other, exacerbating inequities in SRHR service access. Women with disabilities residing in rural areas face compounded challenges due to financial dependence and limited infrastructure, constraining access to essential SRHR services. Physical and sensory impairments intersect with geographical location, creating additional hurdles such as inaccessible healthcare facilities and communication barriers. Disparities in educational opportunities further compound these challenges, limiting women's understanding of SRHR information and perpetuating reliance on inaccurate peer-derived knowledge. These intersectional dynamics highlight the need for targeted interventions that address the multifaceted barriers faced by women and girls with disabilities, ensuring inclusive and equitable access to SRHR services across Sub-Saharan Africa.

The family plays a crucial role in mediating access to SRHR and family planning services, by providing essential support or imposing constraints. Supportive families can empower individuals to overcome societal and religious barriers and effectively communicate SRHR needs to healthcare providers. However, financial concerns, beliefs about the suitability of women with disabilities for motherhood, and religious objections to birth control can limit access to these services.

Young child and her mother washing laundry outside. PHOTO: LEANDER STOLK

Recommendations

From the findings, the following policy recommendations emerge:

1. **COMPREHENSIVE TRAINING FOR HEALTHCARE PROVIDERS:**
   a. Policy level: Mandate regular inclusive communication and disability sensitivity training for all healthcare providers in national healthcare policies. Equip them with knowledge and skills to deliver respectful and non-discriminatory family planning services tailored to diverse disability needs.
   b. Programmatic level: NGOs in the SRHR and disability space should collaborate to create and deliver workshops and certification programs for healthcare providers, focusing on respectful and non-discriminatory family planning services tailored to various disabilities.

2. **TARGETED AWARENESS CAMPAIGNS:**
   a. Policies: Integrate SRHR education specific to persons with disabilities into national curriculums at all educational levels. For example, include specific needs for this group in national adolescent health policies.
   b. Programmatic level: NGOs should design and implement community-based awareness campaigns using accessible formats like braille, sign language, and audio materials. They should partner with local influencers and religious leaders to address cultural misconceptions and empower women and men with disabilities to make informed decisions about their reproductive health.

3. **TAILORED ACCESSIBILITY STRATEGIES:**
   a. Policy level: Enforce regulations that require all healthcare facilities to have disability-accessible infrastructure and services.
   b. Programmatic level: NGOs should work with healthcare centres to encourage and support them to attract necessary resources such as sign language interpreters, sighted guides, and mobile family planning units. Regularly assess and update these strategies to address geographical barriers and ensure continued accessibility.

4. **ADVOCACY FOR ACCESSIBLE SERVICES:**
   a. Policy level: Strengthen legal and funding frameworks to ensure the enforcement of accessible services for women with disabilities.
   b. Programmatic level: Organisations working in the SRHR domain, such as the disability movement, should initiate advocacy campaigns to promote the importance of accessible SRHR services, emphasising the need to bring these services closer to the community. Establish community feedback mechanisms to identify and address ongoing barriers.

5. **COMMUNITY ENGAGEMENT AND FAMILY SUPPORT:**
   a. Policy level: Include community and family engagement as a component in SRHR, health and disability strategies and policies, adopting principles of community-based rehabilitation.
   b. Programmatic level: NGOs should launch initiatives to educate families about the SRHR needs and rights of individuals with disabilities, emphasising the compatibility of modern SRHR practices with religious beliefs. Facilitate open dialogues within families to better support the SRHR needs of persons with a disability.

6. **EMPOWERMENT THROUGH EDUCATION AND VOCATIONAL TRAINING:**
   a. Policy level: Implement policies that ensure access to education and vocational training for people with a disability, including scholarships and financial incentives, and adopt a gender-sensitive lens to include women and girls specifically.
   b. Programmatic level: Launch empowerment programs focusing on financial independence and education for women and girls with disabilities. Provide vocational training and skill-building opportunities to enhance confidence and informed decision-making in SRHR matters.

7. **DEVELOPMENT OF POLICIES USING AN INTERSECTIONAL LENS**
   a. Policy level: Develop and enforce policies that take into account the diverse identities and needs of people with a disability. In doing so, take along intersections of disability, geography, socio-economic status, culture, and education to ensure inclusive SRHR service provision.
   b. Programmatic level: NGOs should intentionally engage in cross-movement building to jointly advocate for the creation of policies using an intersectional lens. They should collaborate to develop programs and initiatives that address shared barriers, leveraging each other's expertise and resources. By implementing pilot programs together, they can demonstrate the effectiveness of intersectional approaches and use the results to influence policy changes and foster mutual understanding about how to best address these barriers.

8. **INFRASTRUCTURE IMPROVEMENT AND TRANSPORTATION ACCESSIBILITY:**
   a. Policy level: Allocate national and local government funds for retrofitting health centres with accessible infrastructure and developing affordable transportation options for individuals with disabilities.
   b. Programmatic level: NGOs should partner and support governmental bodies to retrofit health centres and provide accessible transportation solutions, particularly in rural and remote areas. Conduct periodic audits, e.g. through community score cards, or disability accessibility audits, to ensure these improvements are maintained and continue to meet the needs of persons with a disability.

Credits

Picture on the front page: Mother in conversation with a CBR-fieldworker PHOTO: CHIARA BELTRAMINI

Further reading

This policy brief draws upon the studies and policy briefs that were developed for Zambia, Sierra Leone, Cameroon, and Uganda on the same topic of SRHR:

- **Roadblocks and pathways to inclusion: Access to Sexual Reproductive Health services for women with disabilities in Uganda** - Rupankar Day and Willem Elbers (2024)
- **Intersectional challenges in accessing Family Planning Services: Experiences of women with disabilities in Zambia** – Idah Chanda, Thomas Mtonga and Willem Elbers (2024)
- **Untangling barriers: Towards equal access to family planning for persons with disabilities in Sierra Leone** – Alieu Benjamin Terry, Aisha Fofana Ibrahim and Willem Elbers (2024)
- **Intersectional struggles: SRH access for women and girls with disabilities in Cameroon** – Comfort Jaff, Valentine Ngalim and Willem Elbers (2024)