



**Access for Women with disabilities to Sexual and
Reproductive Health Services in Lira, Northern Uganda:
Experiences, Obstacles and Strategies**

A Research Paper presented by:

Peninah Emiru Amalo (BC5660)
(Uganda)

In partial fulfilment of the requirements for obtaining the degree of
MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Social Justice Perspectives
(SJP)

Members of the Examining Committee:

Dr. Silke Heumann

Dr. Helen Hintjens

The Hague, The Netherlands
December 2013

Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

Inquiries:

Postal address:

Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

Telephone: +31 70 426 0460

Fax: +31 70 426 0799

Contents

<i>List of Appendices</i>	<i>v</i>
<i>List of Acronyms</i>	<i>vii</i>
<i>Abstract</i>	<i>viii</i>
Chapter 1 Introducing the research problem and methods	1
1.1 Introduction	1
1.2 Statement of the Problem	3
1.3 Contextual Background	4
1.4 Structure of the health system in Uganda (Lira)	5
1.5 Research Objective and Questions	6
1.6 Rational and justification	6
1.7 Methodology, Scope and Limitations	7
1.7.1 Choice of Lira District and the informants	7
1.7.2 Techniques of Data collection	8
1.7.4 Ethical considerations	10
1.7.5 Limitations and Challenges	10
1.8 Structure of the Paper	11
Chapter 2 Conceptual and theoretical framework	12
2.0 Introduction	12
2.1 Sexual and Reproductive Health Rights: Global, National and Local Dimensions	12
2.2 Intersectionality	13
Figure 1: Relationship between sub-concepts and SRHR	13
2.3 Sexuality	14
2.4 Debates around Disability and Discrimination	15
2.5 Gender	16
2.6 Class	16
2.7 Conclusion	17
Chapter 3 Intersecting Experiences of WWDs: confronting Stigma and discrimination	18
3.1 Introduction	18
3.2 Experiences through the Lens of Sexuality	18
3.3 Experiences through the Lens of Disability	22
3.4 Experiences through the lens of Gender	23
3.5 Experiences through the Lens of Class	25

Class relations have an economic basis because it defines people's access to resources it also defines people's life choices including the access they have to basic services and other resources (Scott, J. and J. Fulcher 2003).	25
Chapter 4: Obstacles and strategies to improve access	28
4.1 Introduction: Obstacles and Strategies for overcoming Discrimination and Stigma	28
4.3 Conclusion	32
Chapter 4 Conclusion and recommendations	33
Conclusion	33
<i>References</i>	35
Appendices	40
Table 1: The List of Interviewees WWDs with false names that were used to maintain anonymity of my interviewees.	40
Table 2: The List of Interviewees from local government, health workers and NGO key informants interviewed.	41
Table 3: List of Legislation addressing disability in Uganda	42

List of Figures

Figure 1: Relationship between sub-concepts and SRHR.....	Error! Bookmark not defined.
-----------------------------------------------------------	-------------------------------------

List of Appendices

No table of figures entries found.

Acknowledgement

I would like to thank my supervisor, Dr. Silke Heumann and my course convener as well as second reader Dr Helen Hintjens respectively for their patience, support, guidance and understanding during the entire research process. It would not have been possible to produce this paper without their unwavering and outstanding support.

I wish to thank God almighty for his grace upon me all through the entire programme, my sisters and brothers for their prayers, love and encouragement.

My appreciation also goes to NUFFIC, for granting me a scholarship for the study in the Netherlands and to the manager of Health-Need Uganda for his continuous encouragement. Thank you all

List of Acronyms

AIDS	Acquired Immune Deficiency syndrome
ANC	Antenatal care
DDHS	District Director of Health Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICDP	International Conference on Population and Development
LRA	Lord Resistance Army
MOH	Ministry of Health
NGO	Non-Governmental Organization
NUDIPU	National Union of Disable People of Uganda
NUWODU	National Union of Women with Disabilities of Uganda
PWDs	People with Disabilities
SRHR	Sexual Reproductive Health Rights
STPs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TBA	Traditional birth Attendant
UBOS	Uganda Bureau of Statistics
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VHT	Village Health Team
WHO	World Health Organization
WWDs	Women with Disabilities

Abstract

This study seeks to understand the different challenges women with disabilities face in accessing sexual and reproductive health services, taking the case of Lira in Northern Uganda, as a case study. The study will be informed by the following key concepts: gender, disability, sexuality and the principle of access for all women to sexual and reproductive health care services. The concepts also include an element of class, since intersectionality shows that women without education and with a low level of economic security are the most vulnerable to not being able to fully access sexual and reproductive health care services. An intersectional approach highlights the hidden factors, such as psychological and physical health problems, internalized and others' stereotypes, negative body images, biological constraints, socio cultural beliefs, attitudes and relationships, as well as educational and even identity factors. To address these questions, fieldwork was conducted in Lira in July 2015, and interviews were conducted with fourteen women with disabilities, contacted through snowball sampling, to gain insights into their different experiences, which I was concerned to hear from them directly rather than from 'experts' who might talk on behalf of disabled women. I also spoke with two District health officials, in order to facilitate the research process, but also to understand the official policies in place and what services the District offers in general in terms of sexual and reproductive health services. One of the officials provided me with activity reports, which were analyzed to see whether women with disabilities were identified as a target group for health care programs, or not. A third key interview was with a representative of NUWODU, the Ugandan national union of women with disabilities, who informed me of the importance of Gender-based violence in their advocacy program was unable to estimate the number of women with disabilities in the District from any of these sources. Yet the fourteen interviews I conducted with the women themselves went well, and revealed that they faced a number of different challenges, which this study identifies. The key challenges were discrimination, and stigma within the community, including health staff, in relation to disabled women's sexuality. Overall this study concludes that more needs to be done to design specific programs to deal with the diversity of sexual and reproductive health needs of this vulnerable, yet fully entitled, group of women, and for strategies to improve the access of women with disabilities to sexual and reproductive health services to be realized, more collaboration may be needed between NUWODU, the women themselves and local government staff responsible for provision of health care services.

Relevance to Development Studies

Women are the key beneficiaries of sexual and reproductive health services worldwide, therefore their full involvement and utilization of the health products means reduction of mortality and fertility rates which in most cases are causes of high population and poverty in the world but particularly in Uganda. Women with disabilities for many years have been generalized in the health and development policies, although all the women face some form of discrimination when accessing health services it is also good to note that women with disabilities are more stigmatized and discriminated even when it comes to the inclusion of people with disabilities in the government programs and policies they are always generalized. This study contributes to the development literature on how social and cultural beliefs and practices of class, sexuality and gender perceptions have affected access of the women with disabilities to health services. This will be relevant to the development of Lira district and northern Uganda as a region.

Keywords

Women, Disabilities, Sexual and Reproductive Health; Access; obstacles

Chapter 1

Introducing the research problem and methods

1.1 Introduction

Sexual and reproductive health (SRH) is a crucial component regarding the universal rights. (Sommerfeld and Kurup 2011: 200). Concerning the issues that are related to sexual reproductive rights, women with disabilities are among the groups that are treated with disdain by health service providers, viewed negatively or sternly constrained in the services to which they have access (Frohmader and Ortoleva 2014: 3). The case of Lira in Northern Uganda is no exception, and this study tries to examine the different experiences and obstacles faced by Women with Disabilities in accessing sexual and reproductive health services. The findings of this study show in detail that the experiences of WWDs are not homogenous. The variety of experiences is understood in the study of being a result of the intersection of various factors, including gender, sexuality, and disabled status. Discrimination of women with disability by the people is not the main problem experienced by the women with disability, but they are also discriminated from accessing the free healthcare services. Universal rights have always existed to protect the rights of each person (both physically disadvantaged and the advantaged). Its existence enforces the issue of inequity and inequality. Despite all these laws, women with disabilities are still denied the chance to enjoy the healthcare programs as other people do.

Before any successful intervention in regards to the sexual health of WWDs can be achieved, it is important to understand these complex intersections between disability, gender and sexuality. Various studies have demonstrated that it is crucial first to have an in-depth knowledge of factors that influence sexual health for people with disabilities. Then such factors that affect the sexual health of PWDs can be understood, for example, to include psychological as well as physical health problems, the importance of internalized stereotypes, body image, biological aspects, socio-cultural beliefs, attitudes and relationships, as well as educational factors (Taleporos and McCabe 2003, Moin et al. 2009 and Ashtari et al. 2014).

The women with disability have their unique roles in the society despite their differences with other people. Some of their disabilities result due to some major factors such as defects from birth, accidents, among others. Their contribution towards family and society work is seen to some extent. For instance, their work is seen through arts and participation in decision making. In a famous Human Rights Watch report entitled: "As If We Weren't Human," it was revealed that severe ongoing discrimination and sexual abuse was taking place against women with disabilities in northern Uganda (Human Rights Watch 2010, DCDD 2013:1). Such reports and the studies of various non-profit organizations have tried to bring to the forefront of discourse the complex health needs of physically challenged women, by passionately outlining challenges facing such women in Lira district, for example. The challenges include stigma and cultural bias, lack of education and negative attitudes, poor economic rights, and sexual abuse (Blas and Sivasankara

2010:105). However, in this advocacy for rights of women with disabilities, less attention has been paid to girls and WWDs who are seeking to access sexual and reproductive health services. That is what this study aims to do.

It is noteworthy to stress that even with the call for universal access to reproductive health at the Cairo International Population and Development conference in 1994, sexual and reproductive health continue to be neglected and was omitted from the Millennium Development Goals, for example. Sexual and reproductive rights are fundamental human rights that are deeply embedded in various previously recognized national, regional and, international standards, agreements and legal framework. This includes but were not limited to right of everyone to “make free decisions and have full control over their body, sexuality, health, relationships, and if, when and with whom to partner, marry and have children - without any form of discrimination, stigma, coercion or violence” (Frohmader and Ortoleva, 2014: 1). Without exceptions, it is the right of every person to revel in and express their sexuality without any hindrances from taking personal decisions on issues related to their reproductive health. Also, everyone is to have access without obstacles to services, information, and education on sexual and reproductive health (ibid). Notwithstanding, the violation of sexual and reproductive rights of WWDs are not homogenous (ibid), these violations can be understood better by investigating the experiences of WWDs in the process of accessing SHRS.

Quite some studies and reports have reflected extensively on the violations and experiences of the WWDs all over the world. This includes forced and coerced sterilization (Mendez 2013, CRC 2011 forced contraception (Mendez 2013, Frohmader 2013, O'Connor 2011, Dowse, 2004; Jones and Basser Mark 1997). In addition to denial of maternity, parenting & Parental Rights (Frohmader and Ortoleva 2014), denial of legal capacity & decision-making (Frohmader 2013, Grover 2009), inadequate access to SRHS programs and inability to access to information and education on sexual and reproductive rights (Eastgate et al. 2012). Nevertheless, there is a paucity of data that can be used to elaborate the situation of WWDs in Lira district of northern Uganda. Regardless of all available evidence that demonstrates the sorry state of women, children, and elderly persons with disabilities in Lira district as horrifying (FRDC 2012: 1). Unfortunately, women and girls with a disability were not included in the Lira district council five years plan document on health that was released in 2011.

The priority set by the government as the program of national interest were HIV, AIDS, tuberculosis, reproductive health and child survival, malaria and nutrition (Lira District Local Government, 2011:101-103). No single statement can be associated with the interest of women with disability sexual reproductive and health related issues since they will require special medical facilities different to the usual medical treatment arrangement for people (both women and men) without disabilities. The district public health objective under SRH is to establish adolescent friendly services in 36 HCVs, increase health unit delivery from 18% to 40%, increase CYP from 1,308 to 4,500; increase the proportion of pregnant women attending ANC 4 times from 72% to 90% and increase % of HC III and IV providing EMOC from 11% to 100%. However, Within the health indicators given, access to health services stands at 33% district level, compared to national level 49% (HLGSA 2009: 12-22)

In an attempt to contribute to the body of existing knowledge, establish missing links of access to SRH services for WWDs, harmonize data on the experiences of WWDs for better planning and inclusion of WWDs in the interventions of health and developmental programs, this research explored experiences of WWDs in seeking to access sexual and reproductive health services like; condoms, antenatal care, contraceptives, counseling and testing for HIV/AIDs, treatment for STIs services among other aspects in Lira, northern Uganda. Considering the fact that there are different types of disabilities, I focused on two categories of WWDs, those that are physical and visual impairments in Lira, Northern Uganda. For the purpose of this study, I used the concepts of intersectionality that helped understand the intersection of gender, sexuality, disability, and class to analyze the data on the challenges that women with visual and physical impairment of the age 15-59 face in accessing sexual and reproductive health services that I stated earlier.

Since Intersectionality is a concept that deals with categories intersecting and producing unique forms of disadvantages (Davis 2008). This is done to identify and differentiate the experiences of WWDs in accessing SHRS. It becomes imperative to determine what are the experiences of WWDs, how do the intersection of gender, class, sexuality and other related concepts contribute to these experiences, and what are the responses of government other relevant stakeholders in addressing such factors that contribute to such experiences when they are accessing SRHS. Most importantly it will enable us to understand if there are correlations or sharp differences in experiences of the visually and physically impaired WWD. It is important to recognize that WWDs are human and require SRH services like any other human being. Therefore, exploring their experiences in accessing SRH services will not only build on literature but help make these women part of the planning, implementation and evaluation process of services vital for them and policy interventions.

1.2 Statement of the Problem

Women with disability movement led by the National Union of Women with Disabilities of Uganda (NUWODU) remains the only viable voice advocating for WWDs rights and equal opportunities in Uganda (Guzu 2013:3). The central focus of government and other stake holders seems to be on empowering WWDs to actively participate in politics and economic empowerment and less in SRHS.

Women with disabilities face challenges in accessing sexual and reproductive health services in Lira district and factors contributing to such circumstances are inadequately documented. Sheldon and other scholars have argued that women with disabilities cannot be generalized as they have diverse disabilities and challenges all together (Sheldon, 2005; Owens and Torrance, 2013). Accordingly Human Rights Watch notes that these women hardly access even the most basic services, “including health care and justice and have been largely ignored in the post conflict reconstruction efforts” (Human Rights Watch 2010:1). Whereas the government of Uganda has put in place laws and

policies recognizing issues of disability rights and guaranteeing equal access to Health services including sexual and reproductive health services and rights, women with disabilities are observed as not fully enjoying these provisions (Ugandan constitution of 1995 and NUDIPU 2013). In addition to this Human rights Watch points out that sometimes women with disabilities are discriminated when it comes to accessing sexual reproductive health services yet these are essential for the general well-being in matters related to health and human rights of women. Whereas women in general may face difficulty in accessing, WWDs lack access to specific SHRS needs in comparison with able-bodied women but the focus of this study is to critically assess the intersections of the various factors that contributed to their unmet SHRS. I found it interesting to know if a blind educated single woman experiences in accessing SHRS services is similar to that of a physically impaired married uneducated woman.

1.3 Contextual Background

According to the population projections, Uganda is comprised of 35.4 million People, out of which 51% are female (UBOS 2013). Whereas Uganda Population and Housing Census Report (2010) states that 16% of Uganda's population is persons with disabilities, the data is not disaggregated according to sex. The report indicates that the prevalence of disability has been increasing especially among older persons (18%) compared to children (2%) and the most prevalent types of disabilities include loss and limited use of limbs which is (35.3%), spinal cord injuries (22.3%), which are mainly because of the effects of war that lasted for two decades for the case of Lira and other districts in the Northern region. The north has the highest incidence of disability with (4.4%) while the Western Region has the lowest (2.9%). Eastern and Central regions have rates of 3.6% and 3.1% respectively. Although, these statistics are in contradictions with those of the National Household Survey (2005/2006) which estimated that 7% of Uganda's population had a disability, Physical impairments being the highest form of disability (34%), followed by visual impairments (22%) and hearing difficulties (15%), (Owens and Torrance 2013). Often WWDs are invisible both among those promoting the rights of persons with disabilities, and those promoting gender equality and advancement of women (Women Watch 2015). The discrepancy in data limits interventions, in the end few persons with disabilities (PWDs) are accounted for. This causes a strain on services (*Ibid.* 2013).

The Human Rights Watch (2010) report asserts that 20% or more of Uganda's total population have some form of disability, though the data is not disaggregated according to sex. It explains that in Northern Uganda, many WWDs are unable to gain access to basic services, including health care and justice and they have been largely ignored in post-conflict reconstruction efforts. Lira being one of the Districts in the rural Northern region also makes it difficult for the women with disabilities to have access to sexual and reproductive health services since the health facilities are distant and the mobility appliances are a challenge to most women with physical and visual impairments. There is also the issue of low development since the region was affected by insurgency for such a long time. Although Uganda is also said to be

among the countries that have successfully carried out campaigns on HIV/AIDS, there still remains a challenge that not all the communities are accessing this information and the treatment for those who need (Mulindwa 2003). Yet denying women appropriate information on how invasive contraception such as the contraceptive pill, injection or IUD (intrauterine device) works infringes their reproductive rights and may have adverse effects on their health and wellbeing. It can also undermine the efficacy of family planning programmes. Providing this information in ways that make sense of women's own knowledge of their bodies requires an approach that can bridge the gap between bio-medical messages, popular knowledge and lived experience (Cornwall 2002:219)

The State of Uganda Population Report (2013) affirms that reproductive health of persons with disabilities has been overlooked by both the disability community and those working on reproductive health services that have left persons with disabilities more so the women and girls among the most marginalized groups when it comes to reproductive health services. Women with disabilities have needs for reproductive health services as everyone else; the report further notes that, persons with disabilities may actually have greater needs for reproductive health services, like education and care due to their increased vulnerability to cultural and social aspects. The rural women with disabilities are in a worse off situation because of the remoteness that characterizes these areas; where reproductive health services are not easy to access with poor, transport, infrastructure, distance to health centres, inadequate staffs and the stock out of drugs (State of Uganda Population report, 2013).

1.4 Structure of the health system in Uganda (Lira)

The 1995 constitution and the 1997 local government Act mandate the local government to plan budget and implement policies and health sector plans, where the District Director of Health Services (DDHS) is always the lead person responsible for the delivery of health services, recruitment, deployment, development and management of human resource for the district health development and passing of health related by- laws and monitoring of overall health sector performance. The local governments manage public general hospitals, health centres and also provide supervision of all health activities including those in the private sector in the areas of responsibility. The ministry of health provides leadership for the health sector. It takes a leading role and responsibility in delivering of curative, preventive, promotive, palliative and rehabilitative services in Uganda in accordance with the HSSP II (National constitution, 1995 and Local government Act, 1997).

The service points at the district local government therefore, start from the Hospital which is based at the district head quarters normally and offers services like laboratory, X-ray facilities in service training; out reaches to community based health care programs are also organized and coordinated at this level. The health centre IV in Uganda is located at the county level and provides services like preventive, out patients curative and in-patient services, emergency surgery and blood transfusion. Whereas the health centre IIIs are the most important as they act as the mid points between the referral hospital

and the community, this is where most community members access health services like the general health services and sexual and reproductive health services. The health centre II's are based at the parish level and do offer services like antenatal, give first treatment of simple sicknesses and do referrals to the health centre III's for further management and the health centre I known as the village health team is based at the community level. These are a group of some people (*they must be residents of the village where they give information*) trained by ministry of health as the first contact point also known as community focal point persons who do a lot of mobilization of community members whenever there are health activities, like screening of cervical cancer, immunization for infants and many others. For this study the most important points are at the community where the information of the services available is provided and then at the health centre III's where the actual services are accessed.

1.5 Research Objective and Questions

The objective is to understand the challenges and experiences of women with disabilities and their efforts to access sexual and reproductive health services in the existing health facilities within Lira District. The study will narrow down to experiences of physically and visually impaired women in Lira. The main question and sub-questions below will guide to achieve the research objective.

1.5.1 Main Question

How do intersections of gender, disability and sexuality affect women with disabilities (WWDs) experiences in accessing sexual and reproductive health services (SRHS)?

1.5.2 Sub-questions

1. How does sexuality of WWDs affect their access to sexual and reproductive health services?
2. What are the experiences of women with disabilities in accessing sexual reproductive health services and how have these experiences affected their access to SRHS?
3. What strategies have relevant actors (government and NGOs) put in place to addressing WWDs' access to SRHS?

1.6 Rational and justification

Women are the key beneficiaries of sexual and reproductive health services worldwide but still face some level of discrimination when accessing these services more so the women with disabilities whose sexuality is always being questioned even by their fellow women (able bodied). This study will therefore highlight their experiences when seeking to access sexual and reproductive health services. It will help in understanding the dynamic challenges surrounding the access to sexual and reproductive health services by women with disabilities which can then be relevant for policy makers and advocacy of equal reproductive health rights to which Uganda is a signatory to many international human rights treaties that guarantee women's rights, lastly the

research study will contribute literature to the advocates who share the same interest and passion in fighting for a right to equal health services of people with disabilities more so the women with disabilities sexual and reproductive rights. Finally the research will enhance the researchers' knowledge and skills of working with women with disabilities.

1.7 Methodology, Scope and Limitations

This Study started by collecting relevant data through the review of journals, books and articles from different authors/scholars within Uganda and around the world. The focus was on WWDs specifically those with physical and visual impairments. The research used both primary and secondary data incorporating both the qualitative and quantitative aspects of data. To obtain a wealthy body of knowledge, a range of tools like in-depth interviews, key informant interviews and observation were used for primary data. (Creswell (2013) states that interviews focus on individuals or group of people while looking at the problem with the researcher, interpreting the meanings and data collection taking place in the participant's local setting. Doing these interviews therefore, allows room for in-depth understanding of experiences of WWDs in accessing SRH services and observation technique to capture silent communication, body gestures and missing links otherwise not captured during interviews. These helps to build on raw data collected from respondents, guide in finding solutions for improving SRHS to enable WWDs access and utilize the services and at an advanced level inform policy. Bearing in mind that SRH is a complex issue, the researcher sought for permission to interview all respondents and a total of twenty respondents were interviewed (14 WWDs, 2 Government Officials, 3 Health Workers and 1 representative of the NGO). The researcher recognized that the sample size may not represent all the experiences of WWDs in so doing, she reviewed the work of two organizations (NUDIPU and NUWODU) that work directly with WWDs and the Health Management Information System registers (HMIS) of Amaach, , Balaa and Adyel Health centre IIP's.

1.7.1 Choice of Lira District and the informants

Lira Town, located some 350km, from Kampala to the north is an area that was extremely affected by the Lord Resistance Army LRA war that ruined Northern Uganda for more than 20 years until the Juba peace talks that occurred between 2006 and 2008. The absence of security affected mostly women and girls, where many were maimed and had their noses, lips, ears among others cut (GNWP.2011: 139-140). Numeral health centres were attacked, drugs looted and infrastructure destroyed and the population rose to 15% higher than the national level of 12% of persons living in urban areas leaving many rural areas with little or no services (HLGSA 2009: 7), it also represents the districts in northern Uganda following the general prevalence of disability in the country that places the region at 4.4 % highest and lira being the central district in the north can represent the region. The WWDs who were the key informants, it was through the impairments since there are many types of impairments though some have not even been recognised officially, I chose visual and physical basing on the prevalence in the whole country according to Housing and Population Census 2005/2006 and MGLSD (2006), the two

categories of disabilities are high in Uganda and stand at; visual is 20.2% and physical is 35.3% and my focus was also based on the visibility of the impairments. In addition the presence of the two organizations of NUWODU and NUDIPU which work closely with women with disabilities.

1.7.2 Techniques of Data collection

(i) primary data

The primary data was derived from interviewing the 14 women with disabilities, 2 district local government officials, 1 NGO Advocacy officer and 3 health centre III's staff. The interviews provided qualitative information on the challenges and experiences women with disabilities face.

(ii) Secondary data

The researcher reviewed published academic journals, government publications such as annual reports, policy guidelines on sexual and reproductive health. I also made use of internet materials and other relevant scholarly articles available in the library in ISS.

1.7.3 Sampling

Two sampling methods were adopted for this study. Snowball sample and purposive sampling techniques were adopted for the study. It becomes imperative to use the two methods based on the targeted respondents needed to generate relevant data to answer the research questions of this study. According to Cohen and Arieli (2011), in an environment that had been destroyed by conflict such as Lira, conducting research becomes difficult given their complexity and common attitudes of distrust and suspicion. "A threatening political atmosphere could increase the tendency and need of specific, marginalized populations to operate 'underground', far from the public eye. If an environment of conflict is not necessarily one of actual war. Rather, it implies a wider range of adverse social situations (Cohen and Arieli 2011:425). Consequently, snowball sample method is undoubtedly the most suitable method to locate and access people from specific populations in cases where the researcher anticipates difficulties in creating a representative sample of the research population (Cohen and Arieli 2011:426-427). It is usually impossible to determine the sampling error or make inferences about populations based on the obtained sample, in this case the cost of locating samples and researching is not very high. The researcher is not spending time and money trying to find the sample subjects; rather they are being brought to the researcher. Besides, Snowball sampling may help researchers discover characteristics about a population that they weren't aware existed.

Decision to use snowball technique for data collection came up when I came to contact with the in charge of Balaa health centre III one of the facilities I visited with a plan of conducting interviews with the key respondents (WWDs) on convenience but after failing to meet the respondents I shared the idea of my study with the In charge who works closely with most of the respondents, WWDs as one of the health personnel of the Health unit and knew most of the villages of the respondents, he guided me to the home of the first respondent who then also directed me to the next until I was able to cover the first six respondents. The technique demonstrated a level of trust to the researcher that the health worker was able to identify the locality of their

clients which is also a sign that they (WWDs) are visible in the community. The other 8 respondents I requested the officer of National Union of Women with Disabilities NUWODU an organization that works with WWDs closely in Lira. The respondents were attending a training that was organized by another organization called Voluntary Service Overseas VSO. The women and girls were being trained on different areas of hair dressing, tailoring and many others as one way of generating income. So I requested the officer NUWODU and that was how I accessed the women. Making a total of 14 key respondents (WWDs)

One aspect I realized was that if I had taken a conducive sampling I would have used it concurrently with observation method at the health facility that could have given the researcher the chance to view the process WWDs undergo when they are accessing health services at the health facilities and where nonverbal communication was to be used but that was not possible. However, the implications of snowball sampling, the researcher had to be critical with the data as stated by (Van Meter 1990), that in snowball sampling elements are not randomly drawn, but are dependent on the subjective choices of the respondents first accessed, which therefore do not allow the researcher to make claims to generality from a particular sample. Griffiths et al further stresses that, snowball sampling can be biased towards the inclusion of individuals with inter-relationships and networks (Griffiths et al. 1993) and will isolate who is not connected to the network which the researcher cannot access without the insider. These were minimized by the 8 other respondents the researcher was linked to by the NUWODU officer at the district Union.

The purposive sampling method was used to select respondents from the government and health officials as well as the representative of the NGO. Purposive sampling procedure also known as handpicked sampling method incorporates the choice of the key informants to be interviewed, having precise purpose in mind when conducting research (O'Leary 2013: 170). Since not everybody has the needed information that is relevant for my study, prudence dictates that my selection of respondents should be based on what information that I assumed they are holding

The selection of key informants was based on physical and visual impairment (WWDs) while the health workers were important on this study because they are the first contact persons for women seeking SRHS in the health facilities and they have the mandate to deliver the services to the people. The District Director of Health Services was selected because he is responsible for effective and efficient delivery of health services in the district and all the health facilities. The DCDO works for the local government and is responsible for the implementation of community development programs and have interactions with the communities and listen to their concerns and address them accordingly and women with disability are part of community members, and I intended to get the general number of women with disabilities in the district. NUWODU a national organization working directly with women with disabilities in the district was relevant for this study and I had interview with the advocacy officer.

1.7.4 Ethical considerations

Regarding confidentiality, I assured the respondents especially the women with disabilities more so living with HIV that all the information they shared with me would be kept as confidential. I had to explain thoroughly about the use of a recorder during the interview before I could request for informed consent from the respondents (WWDs) since most of them were a bit resistant to give information on grounds that people use them to get funding, and to the district officials the researcher tried hard to be transparent with her intentions of doing research on issues of disability and women as an area for a study and clearly pointed out that she was not spying the work of the ruling government as some official indicated that most people were trying to get gaps in the implementation of the government programs and would easily use that for accusing the local governments as not being accountable to their citizens.

1.7.5 Limitations and Challenges

Having worked with NUDIPU some time for six months, I assumed that it would be easy to request to look at their information on PWDs and also interview one or two staff members. However, it was not simple as I thought even though I eventually got access to the documents that I needed. I had plans to look at the main hospital that is a referral in Lira that supplies the health centers at the lower level and with the guidance of the DDHS but eventually review the Health Information Management Systems HIMS of the three health facilities in the area of study.

There was also a limitation on coverage, for example the researcher could not cover all the women in 13 sub counties who are thought to be visiting one of the 37 health facilities in the district, and since the study was just for one month a sample of three health center III's was reached though it could not adequately represent the whole of Lira district. Getting the statistics of women with disabilities that access sexual and reproductive health services was not easy since the HMIS registers did not have a provisional column for PWDs, in general, making it difficult for the researcher to get accurate information on WWDs, who are benefiting from the health services.

I also faced the general problem in the district when I was referred to the District development officer's (DCDO) office as the department handling public issues of disability in the community and everyone thought I couldn't find data about people with disabilities PWDs but to my surprise I was told the information concerning WWDs could only be got from National Union of Women with Disabilities office. The Union at the district was also not able to give definite information on the total number of WWDs in Lira district, which they claimed that they did not have adequate funds to collect the data about WWDs in the whole area, out of the thirteen sub counties they had only information for seven sub-counties where they are carrying out their interventions has (134) women with different disabilities.

Besides, the respondents were not willing to give information at the beginning with allegations that they were tired of the people who were moving around the community finding out what their problems were *using them for mobilizing funds and votes* and in the end they would get nothing. This was solved when I introduced myself as a student with my student Identification card. The

use of the local language also helped remove the doubt that I was actually not a politician as most respondents thought.

1.8 Structure of the Paper

This study started by introducing the debate surrounding the concept of Sexual and Reproductive rights that is paramount for the accessibility of the SRHS by Women with disabilities in Chapter 1. In this chapter, I discussed the research problem, the context of the problem as well as justification and the importance of the studies, research objectives, questions and sub questions, the methodology adopted, scope and limitations, choice of Lira and the informants, techniques of data collections, ethical considerations, limitations and challenges. Chapter two presents the literature review focus on the theoretical and conceptual framework that was adopted to analyze the data for this study. I present what has been written before on the topic of research as well as critically engaging the concepts of intersectionality, sexuality, disability, class and gender as lens to help understand the intersect in the experiences of women with disabilities in Lira district in relation to accessibility to sexual and reproductive health services. The third chapter presents data and discussion is tailored towards answering the research questions while chapter fourth is the Obstacles and strategies for overcoming discrimination and stigma and the last chapter five presents conclusions of the whole study.

Chapter 2 Conceptual and theoretical framework

2.0 Introduction

The crux of this chapter is a discussion of existing literature around sexual and reproductive health rights and access to SRHS (sexual and reproductive health services) in general and specifically in Northern Ugandan context. Also other relevant concepts are reviewed through the literature, including intersectionality, disability, sexuality, class and gender.

2.1 Sexual and Reproductive Health Rights: Global, National and Local Dimensions

Despite the fact that sexual and reproductive ill health is a major cause of morbidity and mortality, with the exception of HIV and AIDS, the subject has failed to capture broad support from the donor community. Some argue that the notion of reproductive health that was promoted in Cairo 1994 conference was too idealistic, that by emphasizing issues such as empowerment of women and reproductive rights rather than the provision of services and by “asking too much, it ended up getting too little” (Glasier et al. 2006: 2-6). Others make the point that in the current climate of health sector reform, decisions to use scarce funding are based on burden of death and disability attributed to a particular disorder on the basis of measures such as DALYs. Sexual and reproductive health is not only about disease, but also a collection of related health and human-rights issues and many people are still confused about what it consists of (Glasier et al. 2006: 2). Access for WWDs has been a challenge for many therefore; looking at the experiences of WWDs in accessing SRHs will help shed light on what is missing and what needs to be done to ensure they have access to these services.

The Beijing meeting that was held in 1994 in Cairo also reorganised that there was need to promote sexual and reproductive health as a right that women could enjoy freely without restrictions. It therefore recognised the need to fully involve the women with disabilities as well. The universal call therefore was targeted to be achieved by 2015 as one of the goals set for reproductive health and development. People with disabilities were identified as vulnerable with a need for recognition of their reproductive health needs for all girls and women and elimination of discrimination with regard to their reproductive rights (Smith et al. 2004). The above does not indicate that (able bodied women) which means all women have the right and choice to enjoy sexual and reproductive health services freely. However, disability is understood in many different ways in Lira district and in the different communities, it is thought to be a negative factor that limits one from accomplishing what other people, “able bodied” can do and by that many are excluded and always looked down upon in society.

With many countries implementing policies and laws that are not in line with the definition of disabilities stated by the United Nations Convention on

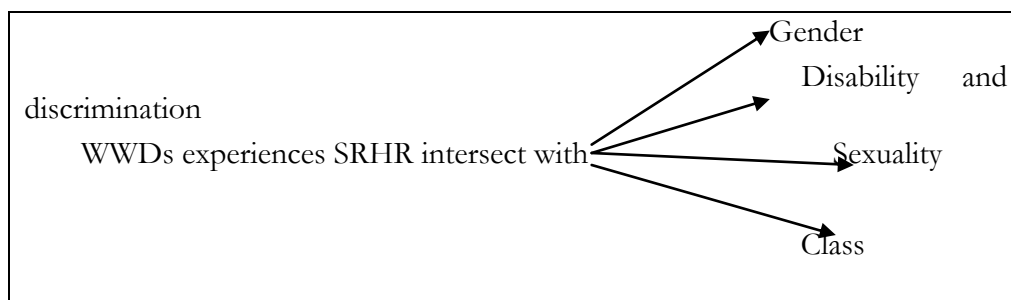
the Rights of Persons with Disabilities (2006).Lira districts in northern Uganda is among the highest population with disability with 4.4% according to HLGSA (2009:7), although it is not a surprise to see the district with such high percentage of people with disability among other districts because Lira is one of the most affected areas during the LRA conflict. UBOS (2012) report indicates that Northern Uganda continues to be highly affected because of the 20 year Lord's Resistance Army (LRA) war that left many with no limbs, trauma and other forms of disabilities.

Nevertheless, Uganda is one of the many countries that; ratified the 1985 Convention on the Elimination of all forms of discrimination against women CEDAW that centred to promote, protect, and respect all the sexual and reproductive rights of women and girls and to eliminate all forms of discrimination against women, enacted a number of laws and policies which make good provisions for persons with disabilities for example the Constitution of the Republic of Uganda (1995) that recognizes the rights of all its citizens to access equal health services at all levels and many other. Sexual and reproductive health therefore was discussed as the rights that were agreed upon in the ICPD 1994, as the rights for all men and women to enjoy freely without discrimination of either, gender, disability, ethnicity or race, although Uganda is one of the counties that is still facing challenges with the promotion of sexual and reproductive health rights.

2.2 Intersectionality

This research used the concepts of Intersectionality, sexual and reproductive health, disability and gender to analyze the data on the challenges that women with visual and physical impairment face in accessing sexual and reproductive health services. Intersectionality is a concept and an approach that emerged out of the feminist thinking in the USA and it was first used in the case of the black women or women of colour in 1960's and 1970's (Samuels and Fariyal 2008), since they were undergoing a number of different problems not only because of their gender but because of race, colour, poverty, class and many others (Davis 2008). Intersectionality also looks at the identity categories as interlocking systems of oppression, and how these overlap to create unequal social relations (Lutz Vivar and Supik 2011:3- 8), in the diagram below, the key concepts used in this study are related to the intersectional approach.

Figure 1: Relationship between sub-concepts and SRHR



Source: Researcher's own design, 2015

Ever since the concept has gained more prominence in the discourse around issues of discrimination, stigmatization and marginalization of minority groups, in other words issues that intersect. Intersectionality (of sexuality, gender, class and disability) allows researchers to understand how these identity categories mutually strengthen or weakens each other, thereby creating unique experiences for women (Winker and Deagle 2011:52), therefore the concept was useful in understanding the challenges of gender, sexuality, class and disability on women with disabilities identities and sexual and reproductive health rights as well as understanding the relationships between how social cultural perceptions link gender, sexuality, disability, reproductive health rights and class etc are maintained and reproduced in the societies and the health facilities settings and how they connect thus making visible the triple burden women with disabilities encounter when trying to seek SRHS and production of power as well as power relations in seeking health services in the facilities.

2.3 Sexuality

In many societies, Sexuality discourse is still a forbidden topic – and a taboo is even much greater for people with disabilities, in particular the women (Nelson 2005, Albertz and Lewiecki-Wilson 2008). Fundamentally, as much as sexuality is important to nondisabled women so it is to WWDs, yet largely is invisible in discourse on Sexual and Reproductive Health Rights and access to services in various community programs. An honest debate about sexuality has been traditionally and historically omitted from the entire health conceptualization, valuation, and treatment of PWDS (Eisenberg et al. 2015: 19). According to Tilley (1996:139), WWDs must deal with how the media's depicted the image of the perfect woman, "complete with the perfect body, the myth of the oversexed or asexual disabled woman, and the feminine mystique which is defined by a traditional, heterosexual marriage complete with children and probably a job". Tilley maintained that the failure of the society to recognize sexuality significance to the well-being of all women and distinguishes disabled individuals as those that are not permitted to love and as a result helps to foist barriers that embolden the repression of their sexuality (Tilley 1996: 140). This implies that the narrative around the image of a perfect woman that has been altered by disability becomes the dominant discourse in many patriarchal societies.

Even in the Western society, disability disrupts the accepted norms and narratives around the women identity in line with body-image, home making and reproduction (Schlesinger 1996 Tilley 1996 Anderson and Kitchin 2000). O'Toole & Bregante (1992:166) notes that there are quite a number of myths that are embedded in these narratives in relation to WWDs and sexuality. For example, unmarried disable women don't have sex and if they do have sex, they did so before they becomes disabled. Another myth highlighted by O'Toole and Bregante, was that WWD are not fit to be a mother that raise a child properly, and moreover they are too fragile to engage in vigorous sexual activities. Besides, WWDs have no sexual emotions, or association; that they (disabled women) should often be grateful for every opportunity of sexual relations they have and that every woman living with disability is heterosexual in nature. A consequence of these myths reflected in the argument of Tilley (1996) that it is unlikely that sex education classes and basic sexual health are extended to WWDs (Andersen and Kitchin 2000: 1165). The more the dominant discourse around the myths gain more support from the society, WWDs might find it difficult to express their sexuality in satisfying ways.

Issues include “body reflection anxiety, physical boundaries, inadequate understanding of sexual and reproductive health, reduced sexual function, and the attitudes of others” (Kassa 2014:583).

2.4 Debates around Disability and Discrimination

Disability is a study of society's interactions with people with physical or mental impairments. It also focuses on the effects of such interactions on the capacities of people with disabilities to lead independent lives (Gleeson 1999). Different traditions have each their own interpretation of disability. Medical model or individual model of disability presents disability as a condition which can be overcome by medical knowledge and rehabilitation. The social model of disability on the other hand sees disability not as individual limitations, but rather as society's failure to meet the needs of people with disabilities (Goering 2010:55).

Disability is not just a health problem. “It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives” (WHO 2001), in this case dealing with the above would require looking at the aspects of environment and the society. The International Classification of Functioning Disability and Health by WHO (2001) defines disability as an umbrella term for impairments, activity limitations and participation restrictions, it states that disability is the interaction between individuals with a health condition, personal and environmental factors e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports”. This definition points out more of the hindrances to person's ability to do something but not about the inability of a person as most people think, thus it is in line with the social model which attributes the challenges of PWDs as caused by the disabling environment.

Medical model makes society view disability as problem by people recognizing the disability in person first as problem and not appreciating that, that is a person not the disability, in other words it makes people not think about Persons with Disabilities beyond their disability (Goering 2010:55). It focuses so much on the needs of Persons with Disabilities as people who need help since they are thought to be ill. Persons with Disabilities according to me are seen to be people who cannot do things that others can do and society has used this way to disable them the more because they are not given chance to try out what they can do but instead they are branded as those who cannot do anything on their own and need help (WHO 2001). Whereas social model looks at the impairment as being caused by the societies and all that is around the (PWDs) as limits to certain services like health, education and access to buildings. The model therefore focuses mainly on issues of discrimination, stigmatization and marginalization of Persons with Disabilities by society and institutions that do not enable them to fit into society freely and on an inclusive basis (Goering 2010). The social model encourages that (PWDs) should be appreciated first before they are blamed because of their different disabilities which makes the model to be geared more on advocacy on the full involvement of (PWDs) in all the positive aspects of development in the different societies. This model then is not in line with the medical model which looks at the impairments more and gives the impression that those with impairments have medical problems which therefore have to be treated. But there are criticisms from other scholars who write that (PWDs) cannot be generalized as they are people with different problems and as a fact their

experiences are not the same (Oliver 1992), Sheldon, 2005 cited in (Owens and Torrance 2013), asserts that, though the social model has been marked as better than the charity model, it's difficult to implement and make it practical.

It is very important that information is available to enhance accessibility. In summary, many SRH interventions involve persuading people who feel well to do things that are uncomfortable, time-consuming or unpleasant whether it is wearing a condom, having a smear or going for antenatal checkups. If women and men are to make appropriate use of sexual and reproductive services, they need more than instructions, inducements or admonishments (Cornwall 2002:220).

2.5 Gender

Gender is another concept that was applied as lens to view the challenges of WWDs in accessing SRHS. The concept is dominantly and traditionally used to define male or female individuals. It is also referred to as the roles, behaviours and activities that a society looks at as good that men and women practice or adapt as the way of life in a community, (Scott 1999). Gender therefore is what people believe and practice, thus a social division and cultural distinction given meaning and substance in every day behaviour, relations and subjective interpretations through which it's lived and since it's a product of culture and social processes, which varies according to time and location (Jackson 2006). Therefore it becomes imperative to use gender in the analyzing the challenges women with disabilities face in the community and at the different health institutions with considerations on the different categories of disabilities.

In spite of the increase in attention given to people living with disabilities, one group that has received little attention or study is the women. Comparable to other social reform actions, the human disability movement has traditionally focused primarily on male experiences as research indicated. For example male spinal cord injuries and employment related issues such as child bearing have received lesser publicity and advocacy synonymous to disabled women (Brooks and Deegan 2014: 229). Thus, the need for supporting WWDs should not be confused to the value of helping generally people living with disabilities, it has been opined that traditionally the undervaluing women was established from outset as a result of sexism, needless to say those who are disabled (Saxton 2012:2). WWDs face two discriminations (1) as women [2] as women with living disabilities (Nelson 2005:2). The situation becomes worse when a woman with disability tested HIV positive, signifying that this woman will be discriminated against about three times over (ibid). The concept of gender therefore will guide in analysing the different intercalations between disability and gender in this study includes both masculinity and femininity since perceptions of gender are deeply embedded in social cultural factors including underlying beliefs about how the society should be.

2.6 Class

Extreme poverty in Uganda is associated with disability and both are inseparable despite remarkable socio-economic achievements recorded in the 10 years in the country. Although no recent data can be consulted to ascertain the current population of PWDs in Uganda, however, past studies suggested that about 2.5 million people are living with different disabilities in Uganda, with most of them living in extreme poverty (Lwanga-Ntale 2003:1). It is also recorded that poverty is responsible for majority of Ugandans, in particular WWDs to remain permanently disabled, as vice versa because "the position of physically disabled women is often economically marginalized" (Brooks and

Deegan 2014:230. The reason is because financially these people are constrained; hence they cannot afford medical bills, many of whom preferred to feed instead of paying health bills as a result of their rudimentary feeding and nutritional lifestyles that make them vulnerable to series of human disabling conditions.

In other perspectives, many people living with disabilities do not have basic access to education and vocational knowledge training, thus making them unemployable. Further still, the physically required nature of unskilful labor makes it also challenging for people living with disabilities especially WWDs to be involved in labor work for sustainability of lives. This condition is even made more difficult because of the absolute exclusions of people living with disabilities from such socio-economic support, constraining them not to participate in the job market (Lwanga-Ntale 2003:1). Class therefore was used as a category to highlight aspects of economic levels of different people in the society and in relation to access to health services at the facilities.

2.7 Conclusion

This chapter talk about the concepts and the structure adopted and used for analysing and interpreting the data in the study. The main concepts looked at include, sexuality, disability gender and class and their relation to sexual and reproductive health services. Intersectionality was used in understanding the relationships between how social cultural perceptions link gender, sexuality, disability, reproductive health rights and class.

Chapter 3 Intersecting Experiences of WWDs: confronting Stigma and discrimination

3.1 Introduction

Regardless of the 2011 World Health Report on Disability emphasis on the dearth of useful information in regards to the SRH needs of WWDs. The available evidence, nevertheless, suggests that persons with disabilities, in particular WWDs have “significant unmet needs” and experience various forms of discrimination in relation to their sexual reproductive health and rights to services. Without a doubt, understanding the how intersections of social factors (gender, class, sexuality, and other related concepts) and environmental (physical factors), structural experiences, and the attitudinal barriers that contributed to the experiences of women with disabilities access to sexual and reproductive health services. This will enable service providers to work toward reducing the barriers that inhibit their access to SRHS, most importantly it will enable them to avoid the misinterpretation of their needs and overcoming the mistreatment they have experienced (UN Women 2012: no page)¹. The findings of this study shows that the experiences of the WWDs in Lira district of northern Uganda are very diverse, even more than what Nelson (2005:2-3) described as “Triple” discrimination.

This chapter presents and discusses the findings of this research in accordance with the theme, objective and the research questions from the study design, focusing on women's experiences. Through semi-structured interviews with the women, the study was able to engage the women with disabilities to identify the various factors that contributed to the experiences that the women with disabilities pass through in seeking to access SRHS. This approach enabled the researcher to understand how the intersection of these factors be it social or physical intersected to impact on their experiences while the engagement with relevant actors (government and NGOs) offered an insight into the response to address such challenges. In order not to confuse the reader, this chapter is divided into four sections in line with the two research questions. This chapter looks into the intersection of social factors mainly sexuality, disability, gender and class. I shall attempt to analyze the experiences of WWDs in accessing SHRS, using the lens of different concepts highlighted earlier in Chapter 3. Intersectionality will be used as it looks at identity categories as interlocking systems of oppression other concepts, as seen through the eyes of women with disabilities themselves, in the interview material.

3.2 Experiences through the Lens of Sexuality

Sexuality according to Dixon- Mueller is a more “comprehensive concept that includes the bodily ability for sexual stimulation and enjoyment (libido) as well

¹ <http://www.endvawnow.org/en/articles/1397-women-with-disabilities.html>

as personalized and shared social meanings attached both to sexual behaviour and the construction of sexual and sexual category” (Dixon- Mueller 1993:273)

Virtually most of the WWDs that I encountered with during the field study reviled that they were abandoned by the men the moment they got pregnant; this led to incidences of single motherhood to be predominant among WWDs. Besides, some girls choose to do abortion with traditional birth attendants as a result of the unwanted pregnancies, with a resultant to potential more complications because they are so ashamed to go to a professional doctor. One of the responses from the respondents shed more light to the above,

“Women with disabilities, most especially the younger ones are abandoned by men after impregnating them because the man is afraid of becoming a subject of mockery that he is not man enough to find a complete girl (a girl without disability). Thus the man, in most cases bow to the pressure and abandoned the woman without help” (WWDs, Lira District).

The above statement indicates that the men who are relating with the women with disabilities do not want to identify with them but relate with the women secretly because of the perceptions of society that women with disabilities are not sexually active, not attractive, not normal and many other myth (Shakespeare 2000), so because of the gender stereotype that real man who is able to demonstrate his masculinity by relating and marrying able bodied woman, exercise his powers as a man and have normal children. Therefore because of the societal norms and beliefs they do fear to openly relate with WWDs and end up visiting them secretly.

The WWDs also shared with me that they don’t have the choice negotiating for safe sex when they are in a relationship, which meant that they could not have choices to use condoms if they wished to protect STI’s and HIV but they could only protect pregnancy with the pills that most of them said they were getting from the hospital, and at times they don’t get it when the health facilities are faced with stock outs of drugs. Most of them also said that they were *having sex by chance not by choice*, WWDs 2015, since most men would be in a relationship with them in secret because of fear that the community could ask them why they were relating with such women.

The above statement portrays that even if the women are aware of their rights to have enjoyable and satisfying sex they cannot exercise their rights because of the gender hierarchy and the male dominance which most male partners want to show that they are in control over the women and with the African cultural norms, a woman has no say about sex when she is not ready to do it and the man wants she has no voice, this is one way power relations are seen when women are not able to speak out their mines but to be submissive to the men even if they are being oppressive, which leaves her with intersection of problems like being very vulnerable to sexual violence, sexual infections, having unwanted pregnancy and above all being abandoned at the end of it all. This is in line with what (WHO 2001 and Nosek et al. 2001) highlighted that women with disabilities are more likely to suffer from sexual abuse and domestic violence more than the able bodied women. In addition the statement of WWDs having sex by chance not by choice means that they feel they can not oppose those who ask them out for a relationship because

they have no choice to choose who they want to sleep with because of the negative societal norms, beliefs and perceptions that they are not normal, not attractive and sexually active, they have lost self-esteem they don't believe on themselves that they can be in good relationships some day and even marry, this then explains why women with disabilities interface different challenges differently even if they all have disability.

“When I had itching and discomfort in my private parts, i went to the health facility and I was asked to take my partner too for treatment if I wanted to be fine” woman with (*Agalo 25years physically impaired one leg lost to landmine 6th /8/2015*)

With regards to visiting the health facilities together with the male partners in the times of testing and treatment of STI's, the WWDs went alone as the men were nowhere to be found, as quoted (*by Akeng physically and uses wheel chair, 5th/8/2015*). The men usually blame women in general when such happens because they do not want to be held responsible for having extra marital affairs they try to use their powers as men which show indications of women with disabilities being more blamed as they are thought to be having multiple sexual partners (Nosek et al. 2001), though this can be right because most men do take advantage of those women with impairments but even the one who might be aware that he is the one who might have brought the infection, though the other challenge is that most STI's do not show at an early stage in the male, they cannot swallow their pride of being a men and able bodied and accept the blame. In addition women with disabilities face double challenge when it comes to the above problem one as women, two as women with disabilities, then having a sexually transmitted disease when they are thought not to be sexually active it becomes a combination of experiences in a woman's life which in most cases is not easy to deal with because of issues of stigma and discrimination that they face both in the society and at the facility.

“When you have sex with a man, he will tell you that I am doing you a favour by sleeping with you; even you suppose to pay me when they want to be extremely rude. It's difficult to find boyfriends with my condition and am still young and need to fulfil my sexual needs” (*Akullo 28years physically impairment one leg, 10th /8/2015*).

The above statement humiliates women with disabilities when those partners they related with tell them openly that they are doing them a favor by sleeping with them. It also points out that the men visit this women with no intentions of having them has their life time partners or with intentions of serious relationships but as secret sexual partners. In addition some men want to act like they trade in sex where they would want women with disabilities to buy them since there is no sign of intimacy and love in such a relationship but is all sexual abuse and exploitations. The social norms and beliefs are so much at play in here because there is an element of gender which shapes the way women are supposed to behave in the society which makes women subordinates of men, the unequal power relations women are supposed to be submissive and are taken as properties of men which means men have power over the women when it comes to sex most especially they feel it's their right to do it their way all they care is about their satisfaction not for the women. The above therefore highlights that sexuality of the women with disabilities is not being put into considerations since most men think that by sleeping with them all is accomplished, they do not think of the sexual feelings of these

women. In addition such statements like am just helping you yet they are exploiting disgrace the women with disabilities and makes them not have confidence in themselves.

Empirically, WWDs in many societies encounter forced contraception's as highlighted by Mendez (2013) and other scholars on one hand. On the other hand, the vast majority of the WWDs that I interacted with during this study in Lira district experienced the inability to use contraception. One of the respondents, a mother of three kids said that

“The problem I have is that my husband doesn’t allow me to use condoms and he will not use too, he always threatened to send me away if I don’t allow him to have sex with me without condom. And sometimes he will abandon me and go to the other wives house, and refuse to come to my house for one or two months as a punishment for disobeying him. Till I go begging him with my co-wives, then he can come back. I can’t lie to you; I don’t live a normal life of a woman sexually because I have no say in this matter” (*Amongi 38years physically Challenged, uses crèches 7th/8/2015*)

Whereas some women with the little knowledge on preventive methods of STIs and HIV would want to use sexual and reproductive health products like condoms, the cultural restrictive norms could not allow them (Smith et al. 2004). Women culturally are taken not to know so much about sex further more to mention issues of protective sex and its more worse with WWDs that are thought to be so inferior and not sexually active. The assumption that PWDs more so the WWDs are not sexually active has played a part in their neglect and marginalization little is known about HIV/AIDS prevalence within people with disabilities but handful studies that are available have raised concerns (Croce 2005), accordingly the exposure of women with disabilities to STIs and HIV infections ideally is deeply embedded in social norms and beliefs that the man chooses to exercise as his powers of masculinity and being a real man not minding of risks of catching diseases from the three women he lives with.

While the issue of sexuality was accentuated from the responses above, one can easily sight the presence of gender and disability strands that positioned women to be submissive to their husband. One of the myths associated with the disability discriminatory behaviours is embedded in the thinking that disabled women cannot be considered as real women. While WWDs may have experienced substantial damage of body parts, or constraint in bodily or mental function on the one hand, Ableism that indicates blatant unfairness against women with disabilities has often been the most reflected idea in sexuality research which has been reinforced by the norms of non-disabled (Campbell 2009:19-20). This notion of able bodied highlights the development of interventions that aim to restore “normal” sexual functioning by primarily pursuing direct biological factors; “however, psychological factors, such as body image, sexual self-esteem, and internalized negative stereotypes about disability, and cognitive issues appear to be particularly salient predictors of the overall psychological well-being of PWDs” Eisenberg et al. (2015: 20). In a decision for any man to abandon WWDs based on the fact that he is ashamed and not want to be subjected to mockery was informed by the sexuality narrative around women. According to Saxton argues that “a disabled

woman's body may be unusual in appearance and judged unattractive by cultural standards" Saxton (2012: 2).

3.3 Experiences through the Lens of Disability

In the Western countries, from my experience people with disabilities are always treated with special care when they are accessing the same public services with those without disabilities, they always come first for example in banks, airports, hospitals, schools, even in private enterprise such as hotels and restaurants. One would not have expected that physically or mentally challenged person to wait on line for many hours. The experiences on sexual reproductive health services of all the women that I discussed with during the field work varies, however, those that are not married or that are abandoned by their husbands share a common element of disrespectful attitudes to them by both the community and health workers. In sharing their experiences, one of the respondents, a double lower limbs amputee said that

“The majority of the people in the community do not treat us with any special care despite our condition. For example, it always takes me extra hours to get to the health centre anytime I am going for my ante-natal appointment and this makes me to be late for the appointment sometimes. Regardless of the pain that I am going through the nurses will not considered the fact I am physically challenged, they will attend to those that I met their first saying when you know that you don't have legs why can't you set out from home early, where is the person that impregnated you”. (*Awino 31years and uses wheel chair 10th /8/2015*)

The above gives a thought that women with disabilities have some expectations when they visit the health facilities, and when their expectations are not met they are able to experience what they perceive that they are not being cared for even though their disability is visible. We can therefore say discrimination is still taking its way as stated by (HRW 2015) that, most of the women with disabilities in Northern Uganda still face a lot of challenges in their own societies and when accessing health services in the facilities, the report further highlights that WWDs health rights are violated.

The statement clearly clarifies that the person who is being treated in a poor way is a woman with disability, on the other hand, it can also be possible that the health worker handling her is an in experienced service provider. It was also noted during the interviews that there are many other cases of women with disabilities who had sworn not to visit the health facilities after being mistreated from the health centres and promised to deal with the elderly mothers in the communities or the traditional birth attendants instead whom the women claimed treat them with care and ask for only chicken as a token of appreciation.

Yet In most cases, people with disabilities are often overlooked by mainstream organizations, even by the disability community when it comes to sexual reproductive health and rights community related issues (DCDD 2013: 1). One thing that I observed during the process of the interviews session is that, women appeared to have low self –esteem because of the health workers and the communities attitudes that continued to stigmatize and discriminate

against them. All women face some kind of stigma and discrimination when accessing sexual and reproductive health services, but WWDs are more stigmatized when it comes to them seeking treatment of STTs more badly the ARVs treatment for HIV/AIDS. The community has in their minds that such a disease cannot be got among the women with disabilities. The society forgets about the needs and feelings of People with disabilities with the assumptions like women with disabilities are less attractive are not sexually active and many others, Shakespeare (2000:162), states that, “the discriminatory attitudes of the society should know that the problem of disability and sexuality is not an inevitable outcome of our bodily differences.” This therefore implies that it’s not about the outward look of the body but it’s about our different feelings inwardly. I realized during the discussions with the women that the men had the confidence to approach the health facilities and simply because they were men. This also highlights the issues of gender looking at power relations as men will always remain men according to different societal beliefs. In addition, a visually impaired woman with two children corroborated the story of the first respondent,

“They will tell you that you think you can hide under the excuse of being disabled to get special favor. You know about this appointment for more than one week, why can’t you arrange for somebody that will bring you here early. These people are so mean and lack human compassion” she stress in her statement (*Apio 29years and visually Impaired 6th /8/ 2015*).

To me the above affirms that women with disabilities interface challenges differently since they have different disabilities and different health needs. In addition it is clear that the health workers have no patience for women with disabilities when they try to seek health services. In addition the above statement highlights that even if women are given appointments for example the ant natal visits and check up that the (MOH guidelines 2008) states that a mother is expected to visit health centre at least four trimesters before she gives birth, due to the distance this women cover and the poor infrastructure, this is in line with (WHO 2015) report which argues that, people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings. According to the (MGLSD 2006), disabilities affect men and women in different ways in Uganda and the impact is more on women than men due to social and cultural roles as women. Furthermore, clients may face barriers to care that are attitudinal and informational as well as barriers that are physical or structural. The report further stresses that attitudinal barriers are seen when care providers do not understand disability for example, when women with disabilities are not offered contraception because they are seen as disabled or assuming that a sexual disabled woman would not desire pregnancy is negative, and limits her access to preconception care. (*ibid*)

3.4 Experiences through the lens of Gender

The Dutch Coalition on Disability and Development (DCDD 2013) fact sheet revealed that more often women with disabilities are subjected to various forms of sexual and emotional abuses that men don’t have to deal with, for instance, issues regarding pregnancy, delivery, and childrearing. Lack of funds and free health care is not the only factor, as identified earlier about the

attitudes of the health care providers. *“Akebi 29years and lost her leg to landmine pointed out that disabled people are considered to be a burden to the society by many” 14th/8/2015*). From her revelation, despite the fact that she is married, supported by family members and educated, she still witnesses the same level of neglect in her attempt to access the SRHS. According to her;

“Anytime when it’s time for me to go to the health centre, I always feel reluctant to go because the way people look at you as you enter the health facility can make you feel like disappearing. If there is no enough space to sit down, nobody will say come and have my seat or the nurses creating space for me to seat down. They will just look at you as if you are not there showing little to zero compassion” *(Akebi 29years and lost her leg to landmine 14th /8/ 2015)*

In accordance with the above statement, cultural norms and beliefs about women with disabilities are rooted differently in socio-cultures that even when a woman with a disability gets married that cannot change the societal perception about her, It also highlights that disability in women is viewed differently by most community members which raises their eye brows when women with disabilities are seen doing what they are not expected to do for example getting married and being pregnant indeed is a human right denial. This kind of act or behaviour seems to be all over the community where these women live including the churches where one would expect to find love and comfort is all the same. I begin to imagine that most communities are really not aware of disabilities and do not know that they can also acquire disability any time. This was pointed out by one of the respondents with no limbs that *“when I go to the hospital people keep looking at me like they have seen something strange” (Adero 30years and no limbs as result of war 5th /8/2015)*.

It gives me an impression that organizations working for people with disabilities have so much to do in the area of awareness creation in the communities and health institutions as well and also to the people living with disabilities because they themselves must have “the confidence, self esteem, and more so be assertive to know and learn since they are living in overprotective environments that denies many disabled people access to formative relationships and sex education” (Anderson and Kitchin 2000). Evidently, the WWDs explanations that they were discriminated against in their communities as well as health facilities whenever they sought for health services is in line with Milligan and Neufeldt (2001:102) argued that there appeared to be ‘double discrimination against WWDs’, with men being considered to be not only deserving of respect but would not be blamed quite as women would be. The WWDs experiences at health centres differ in relations to discrimination, the discrimination is for all women but its more worse if a woman with disabilities visited the health centre and then tested HIV positive she would be discriminated and stigmatized as woman, then woman with disability, woman with disability and having HIV and power low class woman which is beyond. The above worsens the condition of WWDs though if they were not positive they could be discriminated.

3.5 Experiences through the Lens of Class

Class relations have an economic basis because it defines people's access to resources it also defines people's life choices including the access they have to basic services and other resources (Scott, J. and J. Fulcher 2003).

In addition, there are other factors that contribute to the WWDs challenges in seeking to access SRHS, for example the financial factor. One of the respondents said that it was not easy for her to reach the health facility since the distance to the facility was about 5 to 7kms a way. She further pointed out that she had limited access to information and education on Health, Sexual and Reproductive Rights. She said that,

“If you have a wheel chair you are treated differently because you reach the health centre clean, not like us who get to the health facility very dirty and the nurses giving health talk just shout at you openly, it's not easy...”(*Avelo 27years and crippled 13th/8/2015*)

The statement above highlights that women with disabilities are discriminated differently. According to *Avelo's* point to me if one has a means of transport they are treated differently because they look dissent not dirty as *Avelo* stated. So for one to have a wheel chair she should be having money or the family should be able to provide it which implies that she is of a certain class and that makes her to be treated differently. The other is when one has a wheel chair they are able to get to the health facility on time if they set up early whereas those without transportation become more vulnerable when they arrive late at the facilities that doubles their problems. *Avelo* also pointed out that,

“When you have money you can pay boda boda cyclists but many women here in the village have also been crying that the boda boda men abuse them sexually” (*Avelo 27years, crippled 13th/8/2015*).

The environment around the women with disabilities is not safe; the above indicates that they have multiple challenges and that the community members do not fear to cause them more problems. The above is in conformity with what (Smith et al. 2003:1), who states that women in the developing countries faces challenges when accessing sexual reproductive health services that arise from poverty, gender inequality, cultural norms and many others.

In addition, Akebi highlighted that,

“it is not easy to go and give birth in the hospital if you do not have someone to carry you on the bed especially for the women who crawl and those with no lower limbs nobody will carry you unless you have money to give the nurse they cannot help you” (*Akebi 29years physically impaired lost one leg to land mine 14th /8/2015*).

In confirmation to *Akebi's* claim above, *Avelo* also emphasized that,

“Women that are handicap in the lower limbs or those that are crawling like me cannot carry a pregnancy to term, most times we give birth to premature babies which s also a problem to us...”(*Avelo 27years crippled both legs 13th /8/2015*).

To me the statements above means that, if you are just any woman with disability you cannot be attended to in the recommended way by the health policy which recommends equal access to health services to all the citizens, unless you are of some 'class' in other words if you do not have your own relative to help you while in the health delivery room then you should have money otherwise no help. The other possibility is that the nurses at the health center III's do not have adequate knowledge on disabilities therefore they are not patient to help the women with disabilities to deliver normally but prefer to either refer the women for caesarian deliveries or make referrals to the referral hospital in Lira District. The majority of the women also ascribed to the complications during pregnancy and childbirth to the inability of the pregnant WWDs to attend antenatal care. They also gave reasons like distance to the health facilities and lack of mobility appliances which makes it difficult for them to visit the health centers regularly. In accordance with the above argument, Ahumuza and others argued that women with disabilities encounter a range of challenges while seeking to access Sexual and Reproductive Health services which includes but not limited to unfavorable physical structures, distance and long queues at medical centers, undesirable insouciance of service providers and the predominant thinking of the able-bodied people that WWDs ought to be asexual (Ahumuza et al. 2014:1-8), thus, Women and girls with disabilities face double discrimination as a result of their gender and impairments (Mulindwa 2003 and Smith et al. 2014).

In addition, Adero pointed out that,

"I have limited access to information and health education on sexual and reproductive health services..." (*Adero 30years, physically impaired no limbs 5th /8/205*)

She seemed a school dropout, she also said that her husband was a good friend, whom she elaborated that he always accepted to use a condom anytime she demanded for it but her experience is totally different from that of *Amongi who is physically challenged and not educated*. She also said her husband is physically impaired after losing his arm during the Lord Resistance Army conflict which makes her experience to be peculiar and interesting to explore. According to her,

"It is not enough to have all the information of this word about SRHS when you cannot get to where the services are. Apart from the fact that I don't have a wheel chair that can ease my movement around, I don't have money to pay for the services because nothing is free in this country even if they claim that it is free, you still pay some money. I struggle to feed children because my husband is also physically challenged which does not give him the opportunity to work regularly" (*Adero 30years, physically impaired no limbs 5th /8/205*).

Researcher: what kind of employment is he on? *Adero*, he is a cobbler in abeyi wei Center. (*Adero 30years physically impaired no limbs 5th /8/205*).

As the data has demonstrated, even though the respondent has access to information and is in a more egalitarian relationship she faces similar challenges in terms of access to health services as other women with disabilities as a result of the intersect of various factors. *Adero's* scenario highlights the issue of not generalizing the problems of WWDs in the community because they have different needs even if they have disabilities and they interface with

society differently, the above further points out the intersection of mobility, access and affordability of the service itself.

In addition, an interview section with *Akello 32years physically impaired one leg 10th/8/2015* and *Abur 24years physically impaired one leg and the hand 14th/8/2015*, also revealed multiple factors that exclude WWDs from accessing SHRS in Lira district. From the discussion with them, apart from the attitude of the nurses and poverty, lack of education and important information on SHRS is not available to them. *Adur 31years lost her leg to land mine physically impaired* mother of one child revealed that she used to go to the health center but was not aware of sexual and reproductive health services but heard about condoms. It is possible that the times she used to visit the health facility the nurses did not care to give her the necessary information on sexual and reproductive health reason being that she did not ask, which is also possible that she was ignorant about the information. The above also is in line with what (Mulindwa 2003)highlighted that some WWDs were being denied information o some sexual and reproductive health services where he pointed out that most women were not having access to sex education and to condoms, this he stressed as one aspect that was increasing HIV/AIDS prevalence among WWDs, further more in relation to the above, (Fisher 2011:43) highlighted that one way sexual knowledge is denied is in terms of not talking about sex or allowing children to discuss or see sexual imagery, which she said was not putting the rights of the children or those they subjected to abstain. Furthermore they were looking at controlling the pregnancies but not the eventualities that can easily be fold the children for that matter like rape, defilement etc. they were not looking at knowledge as the weapon of all that they were afraid off which is in accordance with what most societal beliefs and norms in Lira are subjecting most WWDs to.

In addition, *Abure* also added that one time she had burning urine and itching around her private parts and when she visited the health facility and the nurse asked for her book but she was not having the book. Without the book she was asked to pay 500Uganda shillings which she did not have. She emphasized on the attitude of the nurses as;

“If the nurse asks you to pay and you tell her that you don’t have money, she will tell you that do you think the government provides us with papers for taking your records. After that, the next thing is to ask you to leave the line and you hear her saying next person” (*Abure 24years, physically impaired no hands 14th/8/2015*).

It is obvious that the supposed free health care is not free despite the fact Physical impaired and other WWDs thought that the government was providing medicines and everything in the health center is free. The findings of this study shows that most WWDs interviewed cannot afford to pay 500 Uganda shillings for a book of 32 pages. WWDs with physical and visual disabilities find it difficult to access free or affordable and quality health care programs accessible by every other person regardless of the universal right to access the same range of these services.

Chapter 4: Obstacles and strategies to improve access

4.1 Introduction: Obstacles and Strategies for overcoming Discrimination and Stigma

This chapter focuses more on the views and recommendations the service providers and the government officials pointed out during the interviews in Lira District. It further highlights the challenges WWDs encounter and the views by the health workers who are always in contact with the WWDs at the health facilities when they seek sexual and reproductive health services.

The United Nations Convention on the Rights of Persons with Disabilities and other international human rights conventions guarantee the fundamental human rights to physical, social, and psychological health of persons with disabilities (Ahumuza et al. 2014:1). On the other hand, available evidence suggests that women with disabilities WWDs still encounter various difficulties in accessing and making use of necessary health services which in turn have impact on their quality of life (Becker et al. 1997:30 and Nosek et al. 1995). Attitudinal prejudices of social service and health providers, physical obstacles in clinic surroundings, and poor dissemination of relevant information just to mention a few are barriers to receiving the required health services include (Nielsen et al. 2012, Frazer et al. 2006). Persons with disabilities also experience dearth of confidentiality and admiration by health interventions besides various facts of their care needs not being recognized (Nielsen et al. 2012, Leigh et al. 2004 and Parish et al. 2007). During the field study, an interview was conducted with the (DDHS) District Director of Health Services Lira, about the district health services in order to have an understanding of what the government is doing to address the needs of WWDs. During the interview, the officer did mention that Lira district was receiving its health services mainly from National medical stores which he said the district would make orders and they could be supplied though others were being pushed. He said, the district was also acting like the store for the health sub districts facilities which were not having refrigerators for most of the sensitive vaccines, he said that,

“Lira district has 37 health facilities though some are not fully functional like the health centre II's that are based at the parish level. Most people come to the sub counties which are quite a distance from the community...” (Mr. Odongo DDHS interviewed 24th/7/2015 Lira district).

From the findings of this study, the services at the district referral hospital are the major operations, admissions, ART, ANC and post natal care, Open patients Dispensing OPD, Sexual reproductive health services SRHS and safe male circumcision SMC. The biggest partners of the district are NUHITS, Reproductive Health Uganda, they come in to try and support in the gaps like facilitating field activities and also to perform some surgeries like the safe male circumcision and family planning for women and doing a lot of health awareness at the community level since most of their activities are community

based. The findings also show that ministry of health is their biggest supplier of condoms and IEC materials; they are also responsible for monitoring the implementation of the health sector. Though the DDHS admitted that the use of condoms was low in the district and that Lira was having HIV/AIDS prevalence of 10% which was higher than that of the whole country which he said was standing at 7%.

In addition, *Mr. Odongo* highlighted that, it was not clear how many people were using sexual and reproductive health services since the records were not put together but his office was very much aware that some people were benefiting from the service. He also noted that most of the communities in Lira needed more health education on sexually transmitted diseases. The officer also noted that the district was facing a challenge of inadequate funds since the government had reduced the budget allocations of ministry of health. He said that most of the health facilities at the health sub districts were under staffed. He also mentioned that the health department had a challenge of taking records since most health facilities are now asking the VHTs to help in triaging the clients, (*Mr. Odongo interviews on 24th /7/2015*).

To me the above statement is not in line with the national constitution of Uganda (1995) which states that all citizens are entitled to equal treatment which is also highlighted in the convention of rights of persons with disabilities (2006) which legislated. According to the DDHS views it seems the district of Lira has more challenges not only in providing sexual and reproductive health services but the health services in general. This can be noted from his view when he mentioned the different health structures and then he emphasized that the most of the health centre II's are not functional and that the VHT's help in dispensing patients. To me this shows that there is a big crisis if VHT's can be given to do the work of the qualified health workers, then we should not doubt when the WWDs complain about how they are being handled. It's then true that the people they meet at the health facilities are actually not medically tried to handled patients not even people with special needs. *Mr. Odongo* also highlighted that Lira district was one of the districts with high prevalence of HIV/AIDS, this also indicates that most communities of Lira district need a lot of health and sexual education on the sexually transmitted diseases but also he did not give the prevalence according to the sex he generalized the data, which leaves us with no clear information of WWDs that are affected.

In line with the above, the District Community Development Officer *Ageno* highlighted that much as they as the local government have tried to build capacity of the WWDs, she stresses that most women are illiterate and therefore it needs a lot of resources to be channelled to empowering the WWDs and the communities where they come from since its where the societal norms and beliefs originate from there is need to think of addressing the issue of cultural beliefs and norms she said that,

“The criteria the government has put for awarding special grant is not favourable for most WWDs because they do not know how to read and write.....”(*Ageno, DCDO an interview on the 27th /7/2015*).

In relation to the above statement by the government officer, I seem to conclude that the government of Uganda is not fully working in line with what the policies and laws state clearly for example the National Constitution of

Uganda (1995), in Article 21 states that, all persons are equal before and under the law in all spheres of political, economic, social and cultural life in every other aspect and shall enjoy equal rights. The Constitution further stipulates that a person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, or social economic standing, political opinion or disability. To me the government is fully aware of the situation of all the citizens in Uganda because all policies and laws are formulated and legislated from the central government with less consultation from the people of the grass roots.

The officer further pointed out that, NUWODU and NUDIPU who are the organizations working directly for women and men with disabilities in the district should join the district and work together so that the women and men with disabilities can be supported. Considering the strong presences of civil societies in Northern Uganda it becomes imperative to investigate the role of the civil societies in assisting WWDs access SRHS in Lira. Madam *Avelo* who is the program officer NUWODU Lira office noted that their work is more of advocacy, networking and capacity building of girls and women with disabilities. In particular she stressed that they mainly deal with cases of gender based violence and human rights. She emphasized that,

“We are not a service provider but more of our work is on advocacy, awareness raising on the rights of WWDs and networking. We work closely with the police in the district and at the lower levels of the sub county and other partners like VSO who were building life skills on the young girls and the women on areas of tailoring, hair dressing and weaving using the local materials as one way of empowering the women economically”. (*Avelo, Advocacy officer interviewed in Lira 29th/7/2015*).

To me the statement above indicates that the local government and the development partners are not actually implementing the same activities, though they seem to have some overlap of some activities. The different statements highlight that the local government and the development partners have different goals that they are working towards. Apparently, the strong presence of NGOs in Lira seem to focus more on aspects Gender based violence and human rights of the affected WWDs, their priority is not SRHS. However women with disabilities had different challenges, she noted that those that were physically impaired but seeing were fair but those with no sight and deaf were the worst. Communicating to them was not easy according to the officer those were the ones that were more abused and denied their rights and the services. She also pointed out the challenge the women were facing as misrepresentation by some of the councillors who knew how to write and read whom she said would always dominate in meetings and trainings and not representing the ideas of all the women with disabilities. The above highlights multiple challenges the women with disabilities face in the different communities, for example they are misrepresented by the fellow either by men or women with disabilities which I can link to the idea that they are illiterate, disabled, poor and they are women so they encounter many other problems in their societies.

4.2 Service Providers

The health workers I interviewed explained their position as local government workers. The nurses defended that they were being generalized as health

workers though they also said that sometimes those who treat patients in a bad way would be because of the work they have. One of the health workers, *Alweng of Adyel* said that,

“The health centre III’s according to the ministry (MOH, 2010) are supposed to have 16 health personnel but we are only 5 working the whole day why then can one shout....” (*Alweng midwife in Adyel H/C III interviewed 31st /7/2015*)

To me the above indicates that the government has shortage of health staff and therefore the few who are there are over worked and therefore they have no time for anybody who visits the health facility and gets them when they are already stressed. They just get mad at the clients simply because they are either tired or stressed. The view above also points out to me that all women face the same challenge but it’s also possible that those who are of a certain class are able to calm down the situation for who their families are in the society and also those who are having some income to please the nurses sometimes buy them soda.

Okello added that the problem of the women with disabilities accessing treatment is not just from the health facility. He stressed that the government gives very little funds for the community out reaches that would benefit the community members and more so those that have problems of mobility but you find that funds are minimal with no transport. The health workers cannot do anything beyond them he emphasized that the young nurses and the medical officers the government sends to the health centres in the health sub districts do not stay in the community, they look for greener pastures and leave that is why we have shortage of staffs and we end up requesting the trained VHT’s to step in and help dispense whenever we have bigger number of clients especially on Wednesdays’, we have mothers coming for ANC clinic. *Mr. Okello further added that,*

“Most of fresh health graduates do not want to work in the village here we have no power, running water so, and the pay is so small compared to the work load. You cannot even save anything for your family....” (*Mr. Okello incharge H/C III Balaa interviewed 4th /8/2015*)

The views shared above highlight that the issue of health and health services in Uganda is just not what can be looked at from the health district and health centre levels, but is clear that it’s a big problem that needs to be looked at right from the ministry of health, how funds are being allocated, health workers welfare and so many others. That is when we can narrow down to the issue of attitudes and manners of the health workers, in other words we need to start from the root causes of all the discrimination and stigma of the clients before we get to the effects that is when we can be able to draw lines and solve the problems WWDs and sexual and reproductive health.

Miss Alumu a nurse in Amaach concluded that, it is also not easy to work with WWDs. She said that WWDs need special care which most of the health workers here lack we have our own weaknesses but they also have their own. She pointed out that we have no special facilities for WWDs like the delivery beds, pit latrines that are specifically for the WWDs, which makes handling them very difficult. The other is that the health workers have less skill on disability issues since they are not included in the medical syllabus in training schools. She concluded by saying that the government through ministry of

health and the development partners like NUHITS, Reproductive Health Uganda, NUWODU and NUDIPU should have clear working objectives that will work towards addressing health and sexual reproductive health issues and cultural norms and beliefs that are constructed around the sexuality of WWDs in Lira district.

4.3 Conclusion

This chapter intended to analyze the different experiences WWDs interface when seeking to access sexual and reproductive health services in the health facilities. Both women with disabilities views and those of the health workers and the district officials were discussed and all of them were highlighting that the challenges that WWDs were facing needed to be looked at right from the central government not just from the grass root level.

However it was also pointed out that most of the problems were also rooted on cultural beliefs and norms of the societies that believed that disability was disease which was causing a challenge to those that were living with it and that those who were having a disability were not able to perform their duties as community expected of them. These perceptions have led to stigma and discrimination of most women with disabilities in most societies in Lira district.

Chapter 4 Conclusion and recommendations

Conclusion

This chapter gives the conclusions and recommendations based on the findings from the field.

The WWDs, encounter a range of factors when they attempt to access health care, sexual and reproductive health services in Lira district, they are excluded and marginalized from accessing reproductive Health services, the manners of service providers towards women with disabilities making them line up the all-day yet they are from far places, contradicting policies, inadequate information on the available health services, high costs for health services and inaccessible buildings and the traditional way of thinking by society that women with disabilities are not sexually active, thought to be non attractive and are inferior (Groce et al. 2013). The findings also brought to the fore various problems WWDs face when in accessing SRHS.

Many women that were interviewed are not educated so they did not know how to read or write for those that were physically impaired, and the ones that virtually impaired were more disadvantaged because they were not even able to use Braille's in case the government was to provide yet they do not have any other means of getting any health information. In general, persons with disabilities face many barriers to care and information about SRH. First is the frequent assumption that WWDs are not sexually active and, therefore, do not need SRH services, The World Health Organization report shows that people with disabilities are sexually active as people without disabilities. Despite this, too often their sexuality has been ignored and their reproductive rights, denied. At best, most existing policies and programs concentrate on the prevention of pregnancy but overlook the fact that many persons with disabilities will eventually have children of their own. Making a brief comparison of all the respondent's testimonies above, one can easily conclude that the experiences are clearly different and as such intervention programs should be tailor-made rather than the proposition of a general plan of intervention.

Recommendations

The challenges of health, sexual and reproductive health services in Uganda need joint efforts in addressing, therefore the government of Uganda should legislate policies and laws that the Ugandan citizens are aware about and be part of the implementation team that is when they can be able to embarrass them and eventually have ownership of human rights programs that can help in cubing down the issues of stigma and discrimination in most communities where the women with disabilities live. Furthermore the government should increase the budget allocations for health so that the health personnel are able to plan for community out reaches that can help in reaching the large community with information on sexual and reproductive health issues that most community members have less access to for reasons like distance, inadequate knowledge and also the attitude of the community members.

Lastly the government should incorporate special needs training in the syllabus of the medical schools so that the nurses can be able to have comprehensive knowledge that can help in handling cases of special needs and the women with disabilities. It's should also promote community sensitization of the cultural and opinion leaders who can then guide in developing strategies of addressing cultural norms and beliefs that most societies are rooted in that promote marginalization of some groups of people in the community.

References

- 1992) 'Changing the Social Relations of Research Production?', *Disability, Handicap and Society* 7(2): 101-114.
- Ahumuza, S. E., Matovu, J. K., Ddamulira, J. B., and Muhanguzi, F. K. (2014) 'Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda', *Reproductive Health* 11(1): 1-9.
- Albertz, M., and C. Lewiecki-Wilson (2008) 'Let's Talk About Sex... and Disability Baby!', *Disability Studies Quarterly* 28(4). Accessed on 16 July 2015 <<http://dsq-sds.org/article/view/151/151>>.
- Allen, S. M., and V. Mor (1997) 'The prevalence and consequences of unmet need: Contrasts between older and younger adults with disability', *Medical care* 35(11): 1132-1148.
- Anastasiou, D., and J.M. Kauffman (2013) 'The social model of disability: Dichotomy between impairment and disability', *Journal of Medicine and Philosophy* 38(4): 441-459.
- Anderson, P. and R. Kitchin (2000) 'Disability, space and sexuality: access to family planning services', *Social Science and Medicine* 51(8): 1163-1173.
- Ashtari, F., Rezvani, R., and H. Afshar (2014). 'Sexual dysfunction in women with multiple sclerosis: Dimensions and contributory factors', *Journal of Research in Medical Sciences* 19(3): 228-233.
- Becker, H., A. Stuifbergen and M. Tinkle (1997) 'Reproductive health care experiences of women with physical disabilities: a qualitative study', *Archives of physical medicine and rehabilitation* 78(12): 26-33
- Blas, E. and A. S. Kurup (2010) *Priority Public Health Conditions: From Learning to Action on Social Determinants of Health*. Geneva: World Health Organization.
- Blas, E., J. Sommerfeld and A.S. Kurup (2011) *Social determinants approaches to public health: from concept to practice*. Geneva: World Health Organization.
- Brooks, N. and M.J. Deegan (2014) 'Women and Disability: The Double Handicap', *The Journal of Sociology and Social Welfare* 8(2): 229-231.
- Campbell, F. K. (2009) 'Disability harms: Exploring internalized ableism', in C.A. Marshall, E. Kendall and R.M.S. Grover (eds) *Disability: Insights from across Fields and around the World*, pp 19-34. London: Praeger Publishers.
- Chireshe, R., E.N. Rutondoki and P. Ojwang (2010), 'Perceptions of the Availability and Effectiveness of HIV/AIDS Awareness and Intervention Programmes by People with Disabilities in Uganda', *Journal of Social Aspects of HIV/AIDS Research Alliance* 7(4): 17-23.
- Clair Kaplan, RN/MSN, APRN (WHNP), MHS, MT (ASCP) (2006), 'Special Issues in Contraception: Caring for Women with Disabilities', *Journal of Midwifery Women's Health* 51(6): 450-456
- Cohen, N., and T. Arieli (2011) 'Field research in conflict environments: Methodological challenges and snowball sampling', *Journal of Peace Research*, 48(4): 423-435.
- Cornwall, Andrea (2002) 'Body mapping: Bridging the Gap between Biomedical Messages, Popular Knowledge and Lived Experience', in: Cornwall, A., and A. Welbourn (Ed.), 2002, *Introduction in Realizing Rights, Transforming Approaches to Sexual and Reproductive Well-being*. London and New York: zed books. Pp 219-
- Creswell, J.W. (2013) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. London: Sage publications.

- Davis, K. (2008) 'Intersectionality as Buzzword A Sociology of Science Perspective on what Makes a Feminist Theory Successful', *Feminist theory* 9(1): 67-85.
- Dixon-Mueller, R. (1993) 'The Sexuality Connection in Reproductive Health', *Studies in family planning* 24(5): 269-282.
- Eastgate, G., E. Scheermeyer, M.L. van Driel and N. Lennox (2012). 'Intellectual disability, sexuality and sexual abuse prevention: A study of family members and support workers', *Australian family physician* 41(3), 135-139.
- Eisenberg, N. W., S.R. Andreski and L.R. Mona (2015). 'Sexuality and Physical Disability: A Disability-Affirmative Approach to Assessment and Intervention Within Health Care', *Current Sexual Health Reports* 7(1): 19-29.
- Fischer, N. (2011) 'Purity and pollution: Sex as a moral discourse', in S. Seidman, N. Fischer and C. Meek (eds) *Introducing the new Sexuality Studies 2nd Edition*, pp 38-44. London and New York: Routledge.
- Frazee, C., Gilmour, J., and R. Mykitiuk (2006) 'Now you see her, now you don't. How law shapes disabled women's experience of exposure, surveillance and assessment in the clinical encounter', in D. Pothier and R. Devin (eds) *Critical disability theory: Essays in philosophy, politics, policy and law*, pp 223-247. London: Sage Publication.
- Frohman, C. and S. Ortoleva (2013) 'The sexual and reproductive rights of women and girls with disabilities', a paper presented at ICPD Beyond 2014-International Conference on human rights, (1 July).
- Fulcher J. and J. Scott (2003) '*stratification, class and status*', in J. Fulcher and J. Scott (ed) sociology, 691-706 Oxford: University press
- Glasier, A. A., M. Gülmezoglu, G.P. Schmid, C.G. Moreno, and P. Van Look (2006) 'Sexual and Reproductive Health: A Matter of Life and Death' *The Lancet Sexual and Reproductive Health Series*. 1595-1607
- Gleeson, B. (1999) *Geographies of disability*. London: Routledge
- Goering, S. (2010) 'Revisiting the Relevance of the Social Model of Disability', *The American Journal of Bioethics* 10(1): 54-55.
- GoU (2012) 2012 *Statistical Abstract*. Accessed 5 May 2015 <<http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2012StatisticalAbstract.pdf>>.
- GoU (2013) 2013 *Statistical Abstract*. Accessed 5 May 2015 <<http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/abstracts/Statistical%20Abstract%202013.pdf>>.
- GoU of Uganda (2014) *National Population and Housing Census 2014 Provisional Results*. Kampala: Uganda Bureau of statistics.
- Groce, N.E. (2005) 'HIV/AIDS and Individuals with Disability', *Health and human rights* 8(2): 215-224.
- Groce, N.E., P. Rohleder, A.H. Eide, M. Maclachlan, S. Mall and L. Swartz (2013) 'HIV Issues and People with Disabilities: A Review and Agenda for Research', *Social science and medicine* 77: 31-40.
- Grover, A. (2009) 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Accessed on 23 August 2015 <<http://www.refworld.org/docid/4aa762e30.html>>.
- Guru, B. (2013) 'Experiences of Gender Based Violence Against women and Girls with Disabilities (A case Study of Uganda)', a paper presented to the N committee on the Convention on the rights and Protection of person with disabilities, Geneva, Sweden (17 April)

- Heckathorn, D. D. (1997) 'Respondent-driven sampling: a new approach to the study of hidden populations', *Social Problems* 44 (2): 174-199.
- Human Rights Watch (2010), 'Uganda: For Women with Disabilities, Barriers and Abuse'. Accessed 3 June 2015 <<http://www.hrw.org/news/2010/08/23/uganda-women-disabilities-barriers-and-abuse>>
- International HIV/AIDS Alliance (2009) '*Linkages and Integration of Sexual and Reproductive Health, Rights and HIV; Seizing Opportunities for Universal Accesses*': Good practice update.
- Jackson, S. (2006) 'Gender, Sexuality and Heterosexuality: The complexity and limits of Heterosexuality'. *Feminist theory* 7 (1): 105-221
- Jones M. and M.L. Basser (1997) 'Female and Disabled: A Human Rights Perspective on Law and Medicine', in K. Petersen (ed) *Intersections: Women on Law, Medicine and Technology* Aldershot, Dartmouth: 49-71
- Kassa, T. A., Luck, T., Birru, S. K., and Riedel-Heller, S. G. (2014) 'Sexuality and Sexual Reproductive Health of Disabled Young People in Ethiopia', *Sexually transmitted diseases*, 41(10), 583-588.
- Kizza, Catherine Mwesigwa. (2013) 'Unsafe abortions kill 1,500 women a year in Uganda'. Accessed on August 13 2015 <<http://www.newvision.co.ug/news/648666-unsafe-abortion-kills-1-500-women-a-year-in-uganda.html>>
- Leigh, I. W., Powers, L., Vash, C., and Nettles, R. (2004) 'Survey of Psychological Services to Clients With Disabilities: The Need for Awareness', *Rehabilitation Psychology*, 49(1): 48-54.
- Lira District Report (2009), *Higher Local Government Statistical Abstract*, http://www.ubos.org/onlinefiles/uploads/ubos/2009_HLG_%20Abstract_printed/Lira%20District%20Local%20Government%20Statistical%20Abstract-Final.pdf.
- Lutz, H., M.T. Herrera Vivar & L. Supik (2011). 'Framing Intersectionality: An Introduction' in Lutz, H., M.T. Herrera Vivar & L. Supik (eds.). *Framing Intersectionality: Debates on a Multi-Faceted Concept in Gender Studies*, 1-22. Surrey, England: Ashgate Publishing.
- Lwanga-Ntale, C. (2003) 'Chronic poverty and disability in Uganda', Accessed 29 August 2015 <<http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1322&context=gladnetcollect>>.
- Máguas, C., H. Griffiths, J. Ehleringer and J. Serodio (1993) 'Characterization of Photobiont Associations in Lichens using Carbon Isotope Discrimination Techniques', *Stable Isotopes and Plant Carbon-Water Relations* : 201-212.
- Mall, S., and Swartz, L. (2012) 'Sexuality, disability and human rights: Strengthening healthcare for disabled people', *South African Medical Journal* 102(10), 792-793.
- McCarthy, M. (2009) 'I have the jab so I can't be blamed for getting pregnant': Contraception and women with learning disabilities', *Women's Studies International Forum* . 32(3): 198-208).
- Méndez, J. E. (2013) 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment', Accessed on 7 August 2015 <http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf>.
- MGLSD (2006) *National Policy on Disability in Uganda*. Kampala: Ministry of Gender, Labour and Social Development.

- Milligan, M.S., and A.H. Neufeldt (2001) 'The myth of asexuality: A survey of social and empirical evidence'. *Sexuality and Disability*, 19 (2): 9191-109.
- Moin, V., I. Duvdevany, I., and D. Mazor (2009) 'Sexual identity, body image and life satisfaction among women with and without physical disability', *Sexuality and Disability* 27(2), 83-95
- Mulindwa, I.N. (2003) 'Study on Reproductive Health and HIV/AIDS among Persons with Disabilities in Kampala, Katakwi and Rakai Districts'. Kampala: Disabled Women's Network and Resource Organization.
- Nelson, D. (2005) 'Women, Sex and Disability—a triple taboo', Accessed 29 August 2015<http://r4d.dfid.gov.uk/PDF/Outputs/Disability/DisabilityKaR_stories_women.pdf>.
- Nielsen, K. K., S. M. Nielsen, R. Butler and J. V. Lazarus, (2012) 'Key barriers to the use of modern contraceptives among women in Albania: a qualitative study', *Reproductive health matters*, 20(40), 158-165.
- Nosek, M.A., C. Howland, D.H. Rintala, M.E. Young and G. Chanpong (2001) 'National Study of Women with Physical Disabilities: Final Report', *Sexuality and Disability* 19(1): 5-40.
- Nosek, M.A., M.E. Young, D.H. Rintala, C.A. Lowland, C.C. Foley and J.L. Bennett (1995) 'Barriers to Reproductive Health Maintenance among Women with Physical Disabilities', *Journal of Women's Health* 4(5): 505-518.
- NUDIPU (2013) 'Alternative Report to the committee of experts on the implementation of the convention on the rights of persons with disabilities (CRPD)'. Accessed 11 May 2015 <http://www.nudipu.org/site/assets/files/1286/crpd_final_report_PDF>.
- O'Connor, J. (2011) 'Literature review on provision of appropriate and accessible support to people with an intellectual disability who are experiencing crisis pregnancy'. Accessed 17 August 2015 <<http://www.lenus.ie/hse/bitstream/10147/122586/1/CPALitreview.pdf>>.
- O'Leary, Z. (2013) *The Essential Guide to Doing Your Research Project*. London: Sage. 2nd edition
- Oliver, M. (Sheriff (2008) 'Identity, oppression, and power: Feminisms and intersectionality theory'.
- Owens, T. and S. Torrance (2013) 'I know my rights, but am I better off?' Institutions and disability in Uganda'. *Credit Research Paper*. 13(3).
- Parish, S. L. and M.J. Ellison-Martin (2007) 'Health-Care Access of Women Medicaid Recipients Evidence of Disability-Based Disparities', *Journal of Disability Policy Studies*, 18(2), 109-116.
- Samuels, G. M., and F. Ross-
- Saxton, M. (2012) Barbara Faye Waxman Fiduccia papers on women and girls with disabilities center for women policy studies May 2012 Barbara Waxman Fiduccia and Disability Feminism: Introduction.
- Scheer, J. and N. Groce (1988) 'Impairment as a Human Constant: Cross-Cultural and Historical Perspectives on Variation', *Journal of Social Issues* 44(1): 23-37.
- Scott, J.W.(1986) 'Gender: A useful category of Historical Analysis', *The American Historical Review*, 91 (5): 1053-1075.
- Shakespeare, T. (2000) 'Disabled Sexuality: Toward Rights and Recognition', *Sexuality and Disability* 18(3): 159-166.
- Sheldon, A. (2005) 'One World, One People, One Struggle? Towards the Global Implementation of the Social Model of Disability'. In C. Barnes and G. Mercer the Social model of disability: Europe and the majority World, pp 115-130. Leeds: The Disability press.

- Smith, E., S. Murray, A. Yousafzai and L. Kasonka (2004) 'Barriers to Accessing Safe Motherhood and Reproductive Health Services: The Situation of Women with Disabilities in Lusaka, Zambia', *Disability and Rehabilitation* 26(2): 121-127.
- Stern, E., Pascoe, L., Shand, T., and S. Richmond (2015) 'Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda', *Culture, health and sexuality*, 1-16.
- Taleporos, G. and M.P. McCabe (2003) 'Relationships, sexuality and adjustment among people with physical disability', *Sexual and relationship therapy*, 18(1): 25-43.
- The Government of Uganda (2013) *State of Uganda Population Report*. Kampala: Ministry of Finance, Planning and Economic Development.
- Tilley, C. M. (1996) 'Sexuality in women with physical disabilities: A social justice or health issue?', *Sexuality and Disability* 14(2):139-151.
- UNFPA (2015) 'Sexual and Reproductive Health'. Accessed 27 July 2015 <<http://www.unfpa.org/sexual-reproductive-health>>.
- Van Meter, K.M. (1990) 'Methodological and Design Issues: Techniques for Assessing the Representatives of Snowball Samples', *NIDA Research Monograph* 98(51.40): 31-43.
- WHO (2001) *The International Classification of Functioning Disability and Health*. Geneva: World Health Organisation.
- WHO (2015) 'Disabilities'. Accessed 28 July, 2015 <<http://www.who.int/topics/disabilities/en/>>.
- Winker, G. & Nina D. (2011). 'Intersectionality as multi-level analysis: Dealing with social inequality' in *European Journal of Women's Studies* (18)1 51-66. Accessed 10 November 2015 <<http://www.ejw.sagepub.com>>
- World Health Organization (2001) 'World Report on disability'. Accessed 3 May 2015 <www.who.int/disabilities/world_report>.

Appendices

Table 1: The List of Interviewees WWDs with false names that were used to maintain anonymity of my interviewees.

No	Name	Sub County	Disability	Age	Date/month
1.	Agalo	Agweng	Physically disabled uses a wheel chair.	25	5 th /8/2015
2.	Adero	Agweng	Physically impaired no limbs has result of war (amputee)	30	5 th /8/2015
3.	Apio	Agweng	Visually impaired	29	6 th / 8/ 2015
4.	Akeng	Agweng	Visually impaired	20	6 th /8/2015
5.	Adur	Agweng	Physically impaired no one leg lost to landmind during the war	31	7 th /8/2015
6.	Amongi	Agweng	physically impaired walks with crêches	26	7 th /8/2015
7.	Akello	Lira	Physically impaired one leg	32	10 th /8/2015
8.	Akech	Lira	Visually impaired	23	10 th /8/2015
9.	Akullo	Lira	Physically disabled one leg	28	10 th /8/2015
10.	Awino	Lira	Physically uses a wheel chair	31	10 th /8/2015
11.	Alumu	Amaach	Visually impaired and HIV Positive.	30	13 th /8/2015
12.	Awelo	Amaach	Crippled both legs	27	13 th /8/2015
13.	Akebi	Amaach	Physically impaired one leg	29	14 th /8/ 2015
14.	Abure	Amaach	Physically impaired no hands	24	14 th /8/2015

Table 2: The List of Interviewees from local government, health workers and NGO key informants interviewed.

No.	Name	Sex	Date	Positions/Occupation of Interviewees
1.	Mr. Odongo Bucaan	Male	24 th /7/2015	DDHS Lira
2.	Mrs. Ageno Molly	Female	27 th / 7/2015	Head of community department. Lira district
3.	Miss. Awelo Phiona	Female	29 th /7/2015	Advocacy officer - NUWODU
4.	Mrs. Alweng Janet	Female	31 st /7/2017	Mid wife- Adyel health center III
5.	Miss. Alumu Sandra	Female	3 rd /8 /2015	Nurse- Amaach health center III
6.	Mr. Okello Tony	Male	4 th /8 /2015	In charge health centre –baala health center III

Table 3: List of Legislation addressing disability in Uganda

No	Legislation / Law	Year	Provision
1.	The constitution of republic of Uganda	1995	Prohibits the discrimination against people with disabilities in Article 21
2.	Parliamentary Elections Statute	1996	Section 37 of the Parliamentary Elections Statute provides for five seats in parliament for representatives of persons with disability
3.	The local government Act and movement Act	1997,1998	These two laws increase the representation of disabled people in the public. The Local Government Act allows representation of people with disability at various local council levels
4.	Traffic and road safety Act	1998	Prohibits the denial of a driving permit on the disability
5.	Uganda communications Act	1998	This law provides for the promotion of research into the development and use of new communications techniques and technologies including those which promote accessibility of hearing-impaired people to communication services.
5.	Workers' compensation Act	2000	Provides compensation to workers who are injured or disabled through industrial accidents
7.	National council for Disability Act	2003	This law monitors and evaluates the rights of persons with disabilities as set out in international conventions and legal instruments, the Constitution and other laws
3.	National Policy on Disabilities	2006,	provides a human rights-based framework for responding to the needs of persons with disabilities
3.	Universal primary Education Act	2006	Makes it financially possible for families to send their children with disabilities to school by providing education to four children in every family including those with disabilities.
10.	Business, Technical, Vocational Education and Training Act No.12	2008	Promotes equitable access to education and training for all disadvantaged groups, including disabled people