‘RAMP’-ification isn't the sole solution.

Access to Sexual Reproductive Health and Family Planning Services for Women with Special Needs: Case Studies from Uganda

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Disclaimer:

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

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Contents

- **Chapter- 1: Introduction**
  - I.I Struggle to achieve sexual reproductive health rights P: 10
  - I.II Challenges and actions to ensure the rights to sexual and reproductive health. P: 10-11
  - I.III Why Sexual Reproductive Health Matters P: 11
  - I.IV Why Uganda? P:12
  - I.V Discrimination figured out through other studies: Brief review of previous studies P: 13
  - I.VI What's different in this study? P:13-14

- **Chapter-II: Methodology**
  - II.I Where the study has been carried out? P: 15
  - II.II How the study has been conducted? P: 16
  - II.III Nature of collected data P:16-17
  - II.IV Brief overview of participation P:17-18
  - II.V Approach of analysing the data P:18-19
  - II.VI Positionality: P:19

- **Chapter-III: Data Quantified** P:23-27

- **Chapter-IV: Unravelling the maze through voices of unheard.** P:28-40

- **Chapter-V: Discussion: Threading theories to empirics.** P:41-53

- **Chapter-VI: Conclusion** P:53-54
  - VI.I Limitations P:55
  - VI.II Policy Recommendations P:56

- **List of Figures**

Fig 1: Map of the location of the study P: 15
Fig 2: Number of Respondents- Healthcare seekers P: 23
Fig 2.1: Number of beneficiary and non-beneficiary based on urban and rural differences P: 23
Fig 2.2: Number of beneficiary and non-beneficiary based on Education status. P: 24
Fig 2.3: Number of beneficiary and non-beneficiary based on Financial status. P: 25
Fig 2.4: Percentage of non-beneficiary based on category of age P: 26
Fig 2.5: Financial status of beneficiaries categorized based on age P: 26
Fig 2.6: Financial status of non-beneficiaries categorized based on age P: 26
Fig 2.7: Categorization of beneficiary and non-beneficiary based on disability type. P: 27
Fig 3: Awareness Poster in Health Centre for Family Planning P: 38
Fig 4: Transformation of resources to capabilities and functioning P: 42
Fig 4.1: Diagram of Levesque Framework for healthcare access P: 43
Fig 4.2: Diagram of integrated analytical framework of research P: 44
Fig 5: Data on unemployment rate of people with disability in Uganda. P:45
Fig 5.1: Data on experiences related to Sexual violence among people with disability in Uganda P: 50

List of Acronyms

- FP-Family Planning
- SRH- Sexual Reproductive Health
- SRHR- Sexual Reproductive Health Rights
- WWD- Women with Disabilities
- WHO- World Health Organization
- UN- United Nations
- UNFPA- United Nations Population Fund
- ICPD- International Conference on Population and Development
- FGD- Focus Group Discussion
- VHT- Village Health Team
- HIV-. Human Immunodeficiency Viruses
- STI- Sexually Transmitted Infections
- NGO- Non-Governmental Organization
- ISS- Institute of Social Studies

~To Maa, Rosho & my brother Ejiro~

Source: War Child

"We are mothers, sometimes by choice sometimes not by choice however even we have emotions, we are also responsible, and we know how to love and care."

People behind this Opus

This research has been part of the project Lilianne Fonds's Breaking down Barriers, which has focused on the capacity building of women with special abilities and roping in NGO's academics and civil society organizations from sub-Saharan African nations, Cameroon, Zambia, Uganda, Sierra Leone. My study has focused on the chapter of Uganda based on the cross-country study related to barriers for women with special needs for accessibility of Sexual reproductive health and family planning facilities. I am genuinely grateful to the Lilianne Fonds teams for all the logistical support, specifically Laura Honders, Kenneth Nangai and Maria Bargslag, for shaping my research path, conversing with me and reading my initial drafts. Special mention also goes to the partner NGO teams in Uganda, the Philomera Hope Foundation, Kalangala and the Uganda National Association for Cerebral Palsy, Kampala. My research assistants for their continuous support in connecting me with the people on the ground and caring for me when I was sick. Thanks, Shams, Irene, and Cathie, for all the support and for going beyond your support. Furthermore, of course, last but not least, all my interviewees, the families and caregivers, and health care professionals have shown interest in coming forward to be part of the study.

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Abstract

Is access to sexual reproductive health and family planning services limited to reproductive needs? However, that is not the case. It is a potential matrix to check on body autonomy and other external factors influencing exercising autonomy without constraining conditions. Hence, it is a fundamental right. Historically, women and the disabled populace have been oppressed groups within the social order, resulting in the limitation of exercise rights. This paper delves deep into the causes, focusing on the factors limiting the accessibility of SRH & FP.

What can be expected from the findings?

This research has uniquely delved into the juxtaposition of resources and identities as well as other converting factor of resources to capitalise on for accessibility of Sexual reproductive and family planning facilities for Women with special needs from Uganda. This research has focused on the external factors categorised beyond disability as a homogenised lens. At the same time, it has concentrated on the heterogeneous individual levels' barriers such as the category of disability, age, patriarchy, religion, and regional disparities. Moreover, support mechanisms like NGOs and family, most importantly, how access to education and finances leads to bargaining power for women with special abilities bodily rights. The thesis wraps up with policy suggestions that focus on individual-based solutions rather than a broad homogenised approach that focuses on the individual's needs that are influenced by external factors.

Relevance to Development Studies

This research bridges the gap between women with special needs and development practitioners by focusing on the factors enabling their reproductive health wellbeing, supporting their individual autonomy through capacity support, and factors influencing the support leading to the transformation of their capability into effectivity for wellbeing.

Keywords

Sexual Reproductive Health (SRH), Family Planning (FP), Women with Disabilities, Intersectionality, Capability Approach, Resources, Conversion Factors

I. Introduction

I.I Struggle to achieve sexual reproductive health rights

The struggle for women's sexual health and reproductive rights has often been associated with deeply ingrained beliefs and societal values that perpetuate gender inequality and discriminatory social norms (Bras & Smits, 2021; Beninga, 2021). As such, women and girls have constantly had to fight for the right to control their sexual and reproductive health and live free from abuse, violence, coercion, and discrimination. However, reproductive health is important. According to Shalev, "Rights to reproductive and sexual health include the right to life, liberty and the security of the person; the right to health care and information; and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility." (Shalev, 2000) Focusing on the accessibility of SRH wellbeing in reality, women's experience and access to the SRHR have greatly depended on their intersecting identities. This is because women's health in general and their sexual and reproductive health are determined not only by their access to health services but also by their status in society and pervasive gender discrimination.

Sexual and reproductive ill-health mainly affects women and adolescents because of their disempowered status in society (Ezeh et al., 2016; Glasier et al., 2006). Thus, even though science and technology have enabled effective interventions to prevent unintended pregnancy, provide safe abortions, help women safely through pregnancy and childbirth, and prevent and treat sexually transmitted infections, millions of women still do not have access to contraception, safe abortion and safe pre and post maternal care (Glasier et al., 2006).

I.II Challenges and actions to ensure the rights to sexual and reproductive health

As per the UNFPA report, on the promotion of sexual reproductive benefits to people with disabilities mentioned that 10% of the world's population, which is approximately 650 million people, are living with a disability. Secondly, out of that populace, 80% is coming from the developing part of the world (UNFPA, 2009); Focusing on their SRHR, it has hugely been curtailed and has been discriminated especially for women with disability.

In the modern era, to guarantee the SRHR of the aforesaid populace there have been formulation of several conventions to guarantee sexual reproductive health as a human right. Discussions are going on, and conventions and treaties are being signed for better access to benefits for the proper functioning of abilities for the full functioning of a human to achieve well-being (Palmer et al., 2009). However, in practice, some are isolated based on their identities shaped by unique abilities, religious values, gender, socioeconomic status, etc (Van Herk et al., 2011; Brown & Moloney, 2019). This paper delves into the nits and grits of the societal norms and values shaped by individual identities and external factors that isolate a few people from acquiring resources and benefits for transforming capabilities for full functioning of naturally acquired abilities to achieve sexual reproductive health and family planning well-being related to women with unique abilities.

Now, before discussing the problem, the question comes among the several categories to achieve well-being in life: Why does sexual reproductive health need to be considered as one of the crucial points for achieving well-being for women and, more specifically, for women with disabilities?

I.III Why Sexual Reproductive Health Matters?

As per the International Conference on Population and Development held in Cairo in 1994, the discourse on sexual reproductive health unpacked the diamond in the coal mine that better sexual reproductive health conditions can be mapped as one of the matrices for the achievement of a woman's empowerment (Fincher, 1994), through physical well-being for achieving empowered status by better access to economic and educational opportunities, achieving autonomy. As Martha Nussbaum has mentioned in her work that "sex-related capabilities (such as bodily integrity, emotional health, and the capacity for sexual expression) are fundamental human capabilities that should not be abridged" (Nussbaum, 2000, P 137).

The focus on the accessibility of sexual reproductive health services to women with disabilities is being triggered based on the prevalence of the isolation of particular abilities within society for not matching up with the dominant or normative set of capabilities. In the hegemony of normative abilities people with disability are considered as the most supressed body in the society (Charlton, 2010; Davis, 2013). Based on the access of getting the benefits of the regular health care services they face discriminations from the institutions influenced by the hegemonical normative norms, while focusing on their sexual reproductive health need, they have little access to support for transforming their abilities into functioning for example failing to perform full or regular pelvic exam (Bhawal, 2014). Stigmatization of their body based on cultural taboos moreover subjugation of people with disabilities based on ideas shaped by societal, religious values and principles, etc.

I.IV Why Uganda?

As per the (UNFPA, 2021a) report, the overall percentage of women with disability among the population in Uganda is 15 percent, and as per a study, there is a high rate of fertility prevailing among women with disabilities in the country, which is almost 6.3% compared to 5.4% within the abled population (Apolot et. Al, 2019). Moreover, under the Sustainable development goal framework, Uganda is one of the prominent African states providing constitutional and legislative protection to this vulnerable population (UNFPA, 2021b). However, most are denied their rights because of prevailing social barriers.

Moreover, the world development watchdog UN, through its Millenium Development programme, could not address the loop of sexual reproductive health needs as a human right and also extend that to integrate people with disabilities (Crossette, 2005). However, to address the more significant needs and the achievement of the rights of people with disabilities, the 61st UN Convention, through its members, adopted a treaty to guarantee rights for persons with disabilities at the general assembly (Nagata, 2007). Furthermore, per Article 25 of the treaty signed in the convention, the member states should ensure equal access to health services for persons with disabilities, explicitly mentioning SRH and population-based public health programmes (WHO, 2009). Per the acclaimed treaty, the preceding measures have been taken through the sustainable development goal blueprint to guarantee their reproductive rights. Uganda has also been part of the convention since 25th September 2008. (Musenyente, Han & Knigge, 2022)

With the acclamation of the treaty signed through the UN convention, significant improvements across the globe are being noticed after more than two decades of the recognition of Sexual reproductive health rights in the Cairo conference of 1994, which has been confirmed by a study conducted by the International Conference on Population and Development (ICPD) (UN, 1994). With the legal protection based on the model of the UN convention, proactive measures have been taken by the member states for the well-being of people with a disability, specifically in the developing part of the world; one example from Sub-Saharan African countries which has taken prominent steps through legislations for their specially abled population is Uganda. However, studies have shown that people in Uganda from the specially abled category face discrimination because of a lack of access to resources and social stigma influenced by cultural taboos (Mostert, 2016; Wilbur et al., 2019 and Nuwagaba & Orech. 2019).

However, women with disabilities face significant discrimination more than men at three levels: first, as the victim of the patriarchy within the society, a person not meeting the normative standard cards of ability within the society and thirdly because of the prevailing social taboo regarding their sexual needs (Nelson, 2007 quoted by Amalo, 2015 & Kiani, 2009).

I.V Discrimination figured out through other studies: Brief review of previous studies

Reports have found that people with disabilities are considered asexual and incapable of giving birth to offspring and taking care of responsibilities. (Addlakha, Price, & Heidari, 2017; Waszczuk, 2017) Hence because of this prevailing notion, primarily women with disabilities are being subjugated to getting access to sexual reproductive health and family planning services. Moreover, besides the prevailing notion, a study (Babalola & Fatusi 2009) has shown that age and ethnicity play a vital role in accessing and utilizing family planning services. Therefore, this research study will focus on whether the failure of family planning programs and access to SHRH services is due to their general incapacity to consider the marginalized identities of women and girls with disabilities.

Moreover, the prevailing societal taboo has sublimed their abilities by oversimplifying it as a disability as it does not fit the normative ability standards. For example, if a person has dyslexia, that does not mean they are incapable of understanding; instead, they are not receiving the necessary resources for up- scaling their abilities (Drew,2023). As per the WHO 2011 statement, mentioned in an article (Dantas et.al, 2020), "The biopsychosocial model of disability places emphasis on impairment, the personal experiences of impairments, as well as the economic, environmental, and social barriers persons with impairments encounter." Through an in-depth review of significant literature on the services and barriers to Sexual Reproductive Health and Family planning services based in Uganda and other parts of Sub-Saharan Africa, it can be infered by saying that although it focused on the structural barriers of the institutions, it does not focus on the varied abilities of women with special needs. (Nixon et.al, 2014). Moreover, studies by (Dotson, L.A., Stinson, J. and Christian, L., 2014) have shown that limited access of SRH and FP services also depends upon the cost, limited access for outreach moreover lack knowledge which can be categorised as resources.

I.VI What's different in this study?

Through capability approach this following research is going to focus on the resources (Nambiar, 2021) which leads to the ability of women with special needs to gets access to the aforesaid benefits.

Beside focusing on the resources leading to the achievement of reproductive well-being even beside that furthermore, a qualitative study was been conducted in Durban (Mavuso, S. S., & Maharaj, P. 2015) on the barriers to care services for women with disability discusses that even if they may have requirements that differ from their non-disabled counterparts, there may be disparities in women's experiences depending on the spectrum of impairments. Women with disabilities are not a homogenous group. Society has looked after the group as homogenous (Turk, Okifuji, Sinclair, & Starz, 1996), rather than focusing on their unique experiences. The capability approach will also focus on their individual needs and experiences rather than following a homogenized lens (Stephens, & Breheny, 2019). Moreover beside a single study conducted based on the intersecting identity barriers faced by

women with disability from minority ethnic communities in post-conflict North Uganda (Mac-Seing, M., Ochola, E., Ogwang, M., Zinszer, K., & Zarowsky, C. 2021) there are little to no existing studies that focus on women and girls with disabilities are marginalized in different ways depending on a 'mix of identities. Existing research ignores the fact that at an individual level women and girls with disabilities experience marginalisation in many ways based on their accessibility of resources such as finances, education etc for being able to afford services moreover also "mix of identities," such as age, kind of impairment, religion, ethnic group, and also contextual or environmental factors of rural vs urban living. All of these at times acts as a conversing factor to capitalise resources for achieving benefits and wellbeing. Leading to some women and girls with disabilities having more or less benefit of SRH or family planning services than others, depending on the mentioned matrixes. The research in this study aims to fill this gap in the literature.

Furthermore, to understand the possible services of the service providers here, in this case, the health care provider has been assessed based on the Levesque framework (Levesque, Harris, & Russell, 2013) which will assess the nature of the service from the demand and supply sides. While discussing demand, it refers to barriers traced to women and girls with disability, and regarding supply, it means the social bias based on inter- sectional identities of the service seeker at the healthcare provisions. Secondly, the research will focus on the Levesque model to understand the link between the service provider and the beneficiary level.

To structure the research the questionnaire has been prepared based on the following research questions and sub questions.

Main Question

How have resources shaped the accessibility of SRH and FP services for WWD?

Sub Questions

- What are the resources for accessibility of SRH and FP services for WWD?
- How do personal conversion factors shape accessibility of SRH and FP services
- How do social conversion factors shapes accessibility of SRH and FP services
- How do environmental conversion factors shape accessibility of SRH and FP services

II. Methodology

II.I. Where the study has been carried out?

The research has been conducted in the semi-urban area of Kampala and the rural district of Kalangala in the Sesse Islands of Uganda.

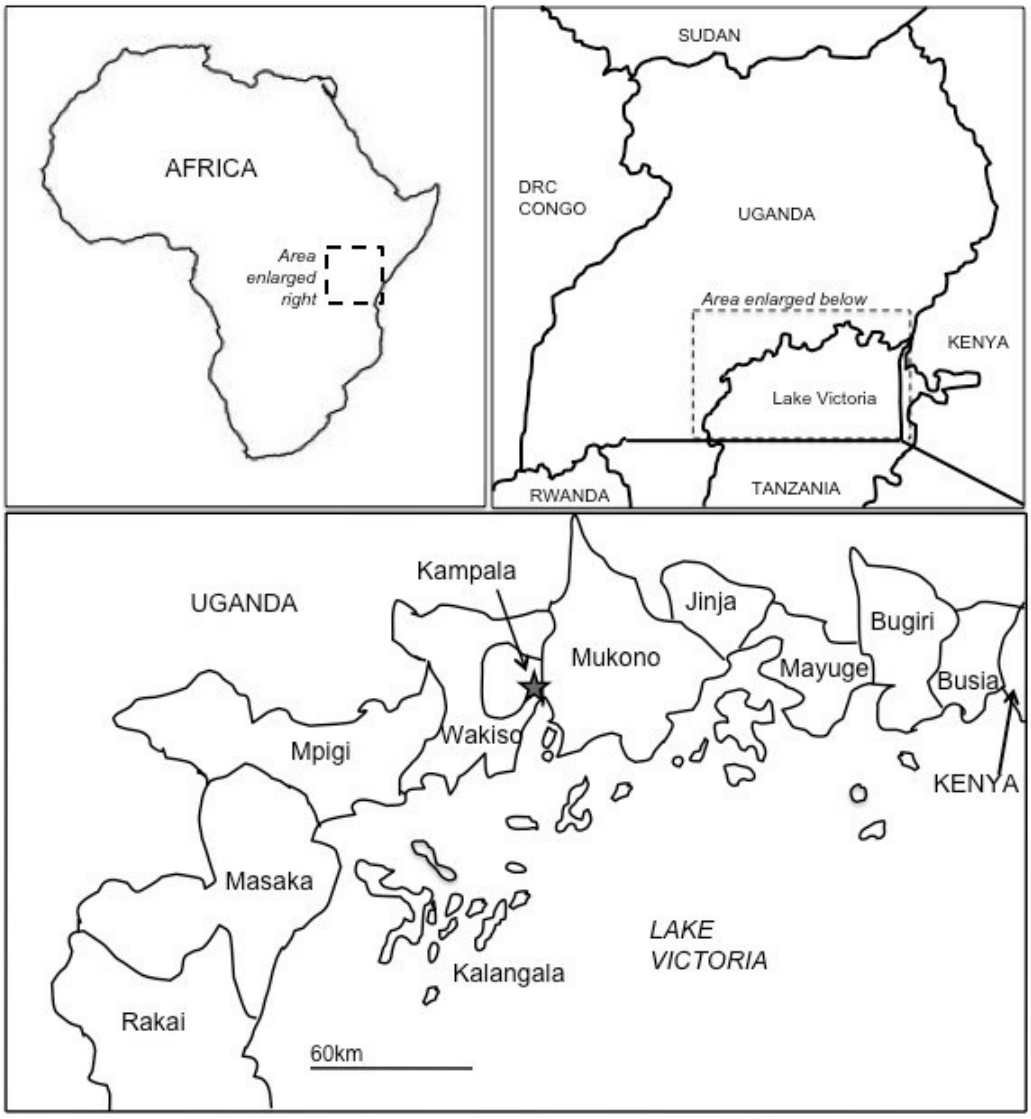


Fig 1: Map of the location of the study

Source: Kabatereine et.al, 2011, p-3

II.II How the study has been conducted?

The research respondents of women come across varied specially abled groups and varied age groups between the range of 18-31. Following the conceptual framework of the capability approach the respondents' financial and educational status have been collected to understand their resource accessibility. For noting the mix of identities for accessing the resource or capitalising those on SRH and FP services focus has been given to identities such as disability status, age, and religion based upon intersectionality lens.

The responses have been collected through in-depth interviews and focus group discussions. The focus group discussions were based on a semi-structured questionnaire guide. The respondents in focus group discussions were formed into a group of 10 service seekers in Kalangala and 6 service seekers in Kampala, and the respondents in the FGDs were entirely different from the individual interviews. The service seekers have been noted to have diverse kinds of impairment, which have been categorised later in a tabular form. During the individual interviews, responses were collected from 8 service seekers who were women with special needs, each from Kalangala and Kampala. During the individual interviews, responses were collected based on semi-structured interview guides as well as through extended conversations based on unstructured interviews to understand the under-layered complexities that women with disabilities face in their daily lives in the form of multiple marginalised identities. Firstly, as a woman in society, as well as because of their marginalised status because of their disability, have contributed to accessibility to resources to capitalise on their well-being.

Additionally, to obtain a more complete picture of the accessibility of SRH and FP services, responses from the supply side have also been gathered following Levesque's healthcare model. Individual responses through interviews have also been collected from the service providers, that is, the health care professionals from both the urban and rural sites. These responses were obtained through semi-structured questionnaire-based individual interviews with medical professionals from both Kampala and Kalangala sites. The names of the respondents have been changed for confidentiality and used for the presentation of the responses from the findings in the later chapter.

II.III Nature of the collected data

The rationale behind choosing both methodologies of FGD and Individual interviews for data collection is that they offer a thorough and balanced picture of

the problem. While focus groups allow us to learn about the consensus on a particular issue (Stalmeijer, McNaughton, and Van Mook, 2014) individual interviews allow us to concentrate on the interviewees' individual experiences, which provides a unique reflection from a variant perspective. Additionally, focus groups help validate the findings made during individual interviews at a broader level; however, to do so, the researcher must assemble a representative sample of respondents with similar backgrounds (Lambert & Loiselle, 2008). The focus group in my study was established using the comparable criteria of age, educational attainment, and financial dependence. This led to the validation of the individual interviews at a macro level; however, it also revealed more detailed information that offered different viewpoints. The research has been conducted first on individual interviews followed by focus group discussion.

The primary reason to choose qualitative research methodology is that the data collected from quantitative research, however rigorous it is, it will still have limitations. It can miss several in-depth intricacies of the responses (Coyle and Williams, 2000). For example, if there is research being conducted that focuses on the economic empowerment of women based on participation in the labour market, it can be found how many women are earning money; however, through qualitative, in-depth collected responses, we can figure out whether earning money is actually bringing the empowered status for them or is it still restricting them under a structure of patriarchy, for example, limitation of women in care work sector it can be only figured out through in-depth conversations with the respondents similarly for this research in order to understand the factor of mix identities and how that is affecting the women with disability in getting the access of the resources to capitalise and how resources is shaping their accessibility.

II.IV Brief overview of the participation

This research has been conducted with the support and connections of the local NGOs in Kalangala and Kampala. I have been connected with the respondents based on their beneficiary or target group of people from their list; hence, we can consider this as purposive sampling because the respondents had been selected based on their lived experience and who are acclaimed with their knowledge to contribute to this research. However, eight beneficiaries and six respondents among the non-beneficiary list have hearing, verbal and intellectual conditions. As a result, I sometimes have to communicate with the caregiver, primarily the respondent's mother in Kalangala. However, in Kampala, I have been accompanied by sign language translators.

Moreover, on both sites, in order to communicate with the respondents, I have been accompanied by translators working with the local NGOs. The research has been conducted in two phases in both sites from the 11th of July 2023, to the 8th of August 2023. In the first phase, in order to understand the cultural context, I have

had conversations with local people regarding disability and how they perceive the sexual needs of women with disabilities in order to understand how the local environment is influencing the primary respondents to get access to the service in the second phase interviews have been taken individually at the beneficiary level also service delivery level. At the service delivery level, responses have been taken from health care professionals from faith-based health centres, public and private health centres, and village health team professionals.

Respondents from Rural Kalangala

- Healthcare Seekers: 8 individual interviews
- Focus Group Discussions: 10 participants.
- Village Health Team (VHT) Member: 1 individual interview
- Healthcare Providers: 5 individual interviews (1 Private, 2 Government-run, 1 Church-run)

Respondents from Semi-Urban Kampala

- Healthcare Seekers: 8 individual interviews
- Focus Group Discussions: 6 participants.
- Healthcare Providers: 3 individual interviews (Private, Government-run, Church-run)

II.V Approach of analysing the data

During the fieldwork, a notebook was kept writing observatory notes and handwritten transcripts as conversation excerpts. Additionally, verbal consent had been taken and noted from each interview respondent.

After completion of the interview, the responses were coded based on inductive and deductive coding; from the inductive coding, it became evident that access to resources plays a significant role in accessing services to SRH and FP.

Inductive and deductive coding are approaches for analysing qualitative data sets from interviews. In inductive coding, the researcher takes the raw data set from the interviewee's responses, highlights paragraphs and segments and puts that into themes contextualised based on the research question. In deductive coding, the raw

data or responses are analysed based on the concepts or theories that frame the research question (Azungah, 2018).

After collecting the responses through the interviews, the responses have been coded and themed manually and also through Atlas Ti 2023. The significant themes selected from the codes through the research are financial autonomy, Vocational Education, Accessibility of Infrastructure, Family support, and Identities. These central themes have been integrated based on the pre-existing theory of this research based on a deductive approach; however, codes which could not be accommodated have been added in the thesis, which has been integrated with relative academic concepts.

The research has been conducted based on varied social sets, more specifically urban and rural setups, in order to understand the accessibility to services; Kampala has been selected based on researchers' assumption that it will have better-structured services than Kalangala and reason to choose Kalangala as it is one of the poorest districts moreover it is known for its highest number of HIV rates for decades and over 24-30% of the populations are HIV infected (Piacenza, 2012, p-7) hence women with disability are the most vulnerable.

II.VI Positionality

Being a brown Indian man from the Netherlands, it was difficult for me to understand the local language and sign language since I was not trained in it; hence, I have been accompanied by research assistants and translators who have finished their undergraduate in public health policy. The research assistants and the translator are from the local partner NGOs of Lilianne Fonds in both the sites. The research assistants have been women from the local community and young developmental professionals at the community level who are working with the targeted group of the research in several projects where they have been working with families and individuals and connected individually and have close relationships for years. However, although the research assistant and translators were the first points of contact with the respondents, their collected responses have been cross-checked. The research assistants have also been trained and communicated about the objectives of their research and the data collection methods. Moreover, they also have the experience of research assistantship with other national and international researchers who have worked in the same community. The local women have been selected by the NGO professionals who are partners in the research; the sign language translators have worked as midwives on SRH of women with disabilities for two years, as an intern and later as full-time medical professionals.

Table I. Brief overview of respondents noted as beneficiaries of SRH and FP services from both the sites

Beneficiary	Place	Age	Education	Financial Status	Disability Category	Kind of Service
A	Kalangala	23	No formal or informal education	Dependent	Hearing and Verbal Impairment	FP
B	Kalangala	26	No formal or informal education	Dependent	Hearing and Verbal Impairment	FP
C	Kalangala	29	No formal or informal education	Dependent	Hearing and Verbal Impairment	SRH & FP
D	Kalangala	26	Vocational course in Bakery	Independent	Mobility Issues	SRH
E	Kampala	28	Finished Master's	Independent	Cerebral Palsy	SRH
F	Kalangala	26	Vocational Training in Stitching	Independent	Mobility Issues	SRH
G	Kalangala	27	Vocational Training in Stitching	Independent	Mobility Issues	SRH
H	Kalangala	27	Vocational Training in Stitching	Independent	Mobility Issues	SRH
I	Kalangala	28	Vocational Training in Stitching	Independent	Mobility Issues	SRH
J	Kalangala	29	Vocational Training in Stitching	Independent	Mobility Issues	SRH
K	Kalangala	29	Vocational Training in Stitching	Independent	Hearing and Verbal Impairment	SRH
L	Kalangala	26	Vocational Training in Stitching	Independent	Hearing and Verbal Impairment	SRH

M	Kalangala	27	Vocational Training in Stitching	Independent	Hearing and Verbal Impairment	SRH
N	Kalangala	30	Vocational Training in Stitching	Independent	Hearing and Verbal Impairment	SRH
O	Kalangala	26	Vocational Training in Stitching	Independent	Hearing and Verbal Impairment	SRH

Source: Author

Table II. Brief overview of respondents noted as non- beneficiaries of SRH and FP services from both the sites

Non-Beneficiary	Place	Age	Disability category	Financial status	Education Status
A	Kalangala	23	Multiple disabilities (Hearing and Verbal, intellectual)	Dependent	No formal or informal education
B	Kalangala	26	Multiple disabilities (Hearing and Verbal, intellectual)	Dependent	No formal or informal education
C	Kalangala	18	Intellectual	Dependent	No formal or informal education
D	Kalangala	19	Hearing and Verbal Impairment	Dependent	No formal or informal education
E	Kampala	25	Intellectual	Dependent	No formal or informal education
F	Kampala	23	Intellectual	Dependent	No formal or informal education
G	Kampala	21	Intellectual	Dependent	No formal or informal education

H	Kampala	20	Multiple disabilities (Hearing and Verbal Impairment,, intellectual)	Dependent	No formal or informal education
I	Kampala	25	Multiple disabilities (Hearing and Verbal Impairment, intellectual)	Dependent	No formal or informal education
J	Kampala	27	Cerebral Palsy	Independent	Finished MA,
K	Kampala	26	Intellectual and verbal	Independent	Trained in Tailoring through vocational training
L	Kampala	20	Hydrocephalus	Dependent	No formal or informal education
M	Kampala	18	Blindness	Dependent	No formal or informal education
N	Kampala	19	Hearing and Verbal Impairment	Dependent	No formal or informal education
O	Kampala	19	Intellectual	Dependent	No formal or informal education
P	Kampala	20	Intellectual	Dependent	No formal or informal education
Q	Kampala	19	Dyslexia	Dependent	No formal or informal education

Source: Author

III. Data Quantified

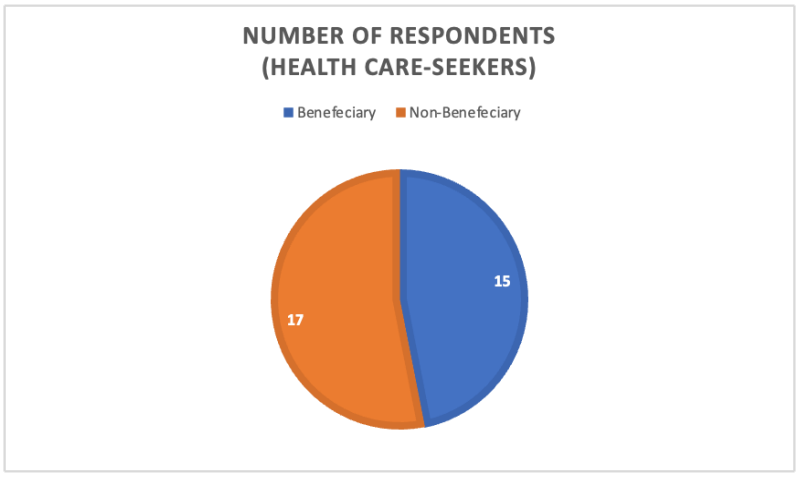


Fig 2: Number of Respondents – Health care seekers

Out of all the responses collected from both the sites of Kalangala and Kampala, the total number of respondents is 32 individuals, including the individual interviews and the focus group discussions.
Of the 32 respondents, 17 are noted as non-beneficiary, while 15 are not as beneficiaries. So, in this study, the number of non-beneficiaries is more than the number of beneficiaries.

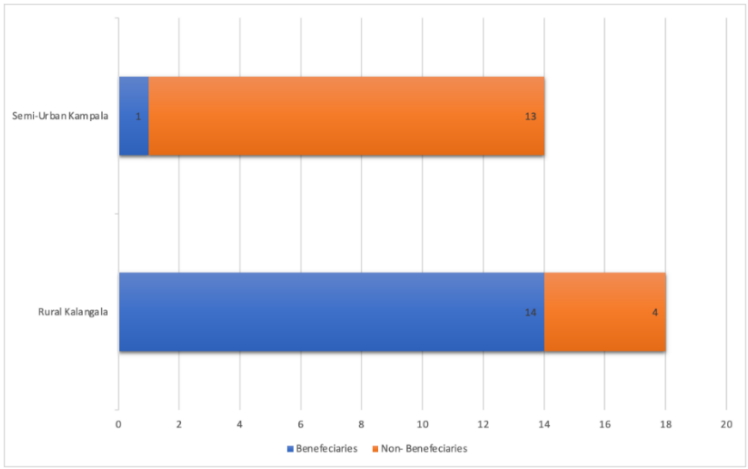


Fig 2.1: Number of Beneficiary & Non-Beneficiary based on Urban and Rural differences

Based on the collected data, there are more beneficiaries in rural Kalangala, while on the contrary, there are fewer beneficiaries in Kampala. However, Kampala has a more significant number of non-beneficiaries. Through the graph, we can see 1 beneficiary in Kampala, while there are 14 in rural Kalangala, 13 non-beneficiaries in Kampala and 4 non-beneficiaries in Kalangala.

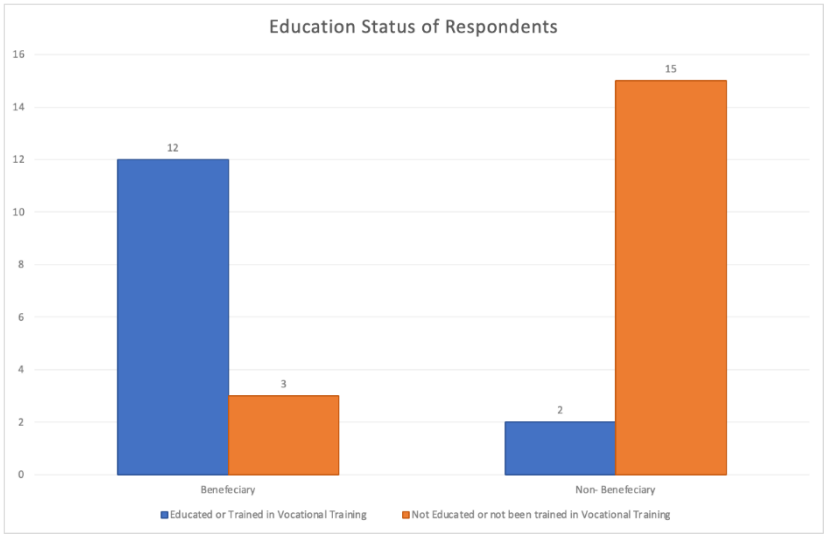


Fig 2.2: Number of Beneficiary & Non-Beneficiary based on Education Status

Education has been noted as a prominent category among the respondents regarding the accessibility of SRH and FP services. Here, in the case of education, vocational training has also been part of the consideration. It not only shapes the financial autonomous status of Women with special needs by increasing their bargaining power, but education also shapes confidence by breaking self-stigmatization and being more vocal about individual SRH and FP needs. From the above bar diagram, we can notice that out of the 15 beneficiaries, 12 are educated or trained in vocational courses, while 15 out of 17 are not educated or trained in any vocational courses. There is a prominent reflection on a broader scale that Educated women with special needs have more accessibility to the SRH and FP services than their non-educated or non-vocationally trained counterparts.

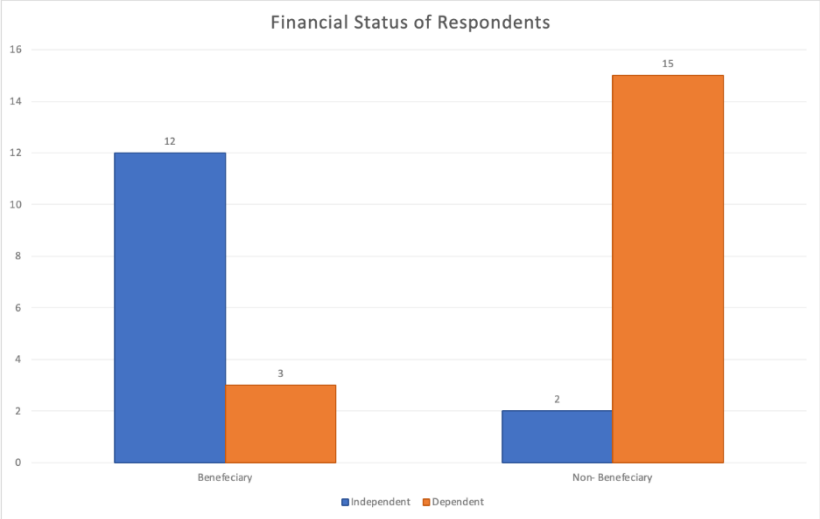


Fig 2.3: Number of Beneficiary & Non-Beneficiary based on Financial Status

In the following bar chart, it has been shown based on the quantitative presentation of the data that there are more financially independent women with special needs who have been categorised as beneficiaries on a macro level; however, it has also been seen that it has not been the case always for example out of the 15 beneficiaries 12 are financially independent 3 are dependent. On the other hand, in the case of the non-beneficiary list of 17 respondents, 15 are dependent financially, while 2 are independent.

So, there is a contrast: finances only sometimes guarantee the services. Also, for those who are financially dependent but considered beneficiaries, is it genuinely transforming their SRH and FP capabilities? The follow-up with the answer will focus on the next chapter of the qualitative presentation of the finding.

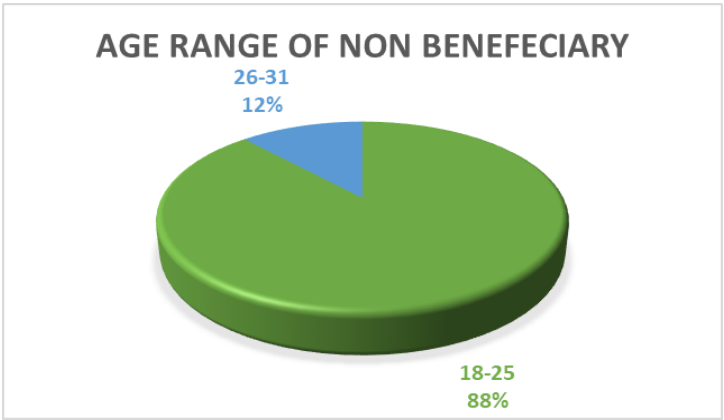


Fig 2.4: Percentage of Non-Beneficiary based on the category of age

Based on the intersectionality criteria, while taking responses based on age category, it has been noticed that 17 women who have been noted as non-beneficiary are 15 from the age group of 18-25 and 2 from 26-31. The reason behind that age-based deprivation is also because of the accessibility of financial resources in the upcoming diagram that has been noted focusing upon the financial dependency based on age.

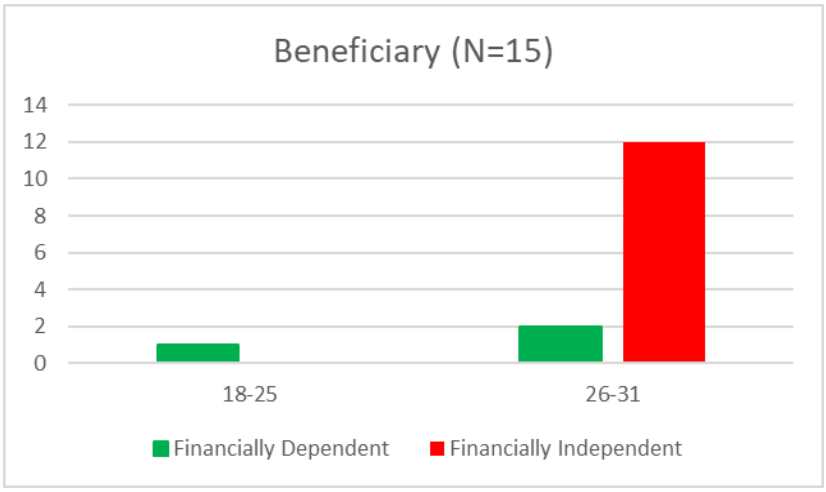


Fig 2.5: Financial status of Beneficiaries categorised based on age

From the beneficiary list of 15 respondents provided through a table in the previous chapter, it has been noticed that only 1 of the women coming from the age range of 18-25 and 2 coming from the age range of 26-31 are financially dependent, and the rest 12 between the age range of 26-31 are noted as financially independent.

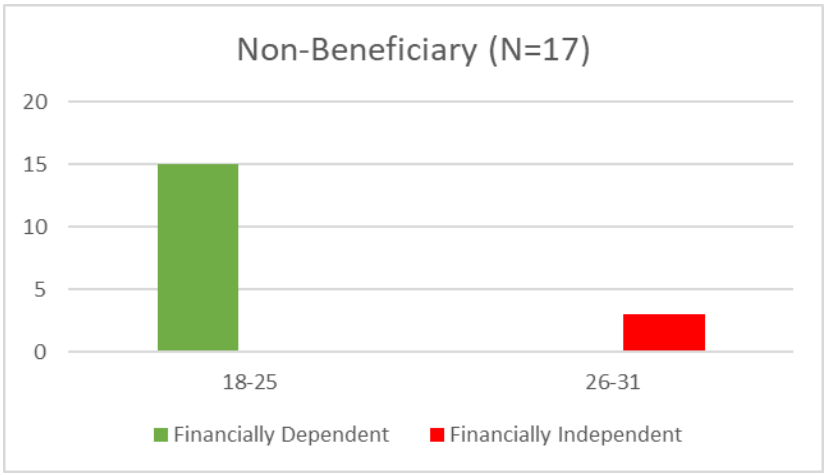


Fig 2.6: Financial status of non-beneficiaries categorised based on age

While checking on the non-beneficiary list of 17 respondents, most women with special needs, 15 are financially dependent, coming from the age group of 18-25 while the other 2 noted as independent are coming from the age group of 26-31. Hence, it can be noticed that access to finances is also shaped by the identity of age, which will be discussed in the later chapters.

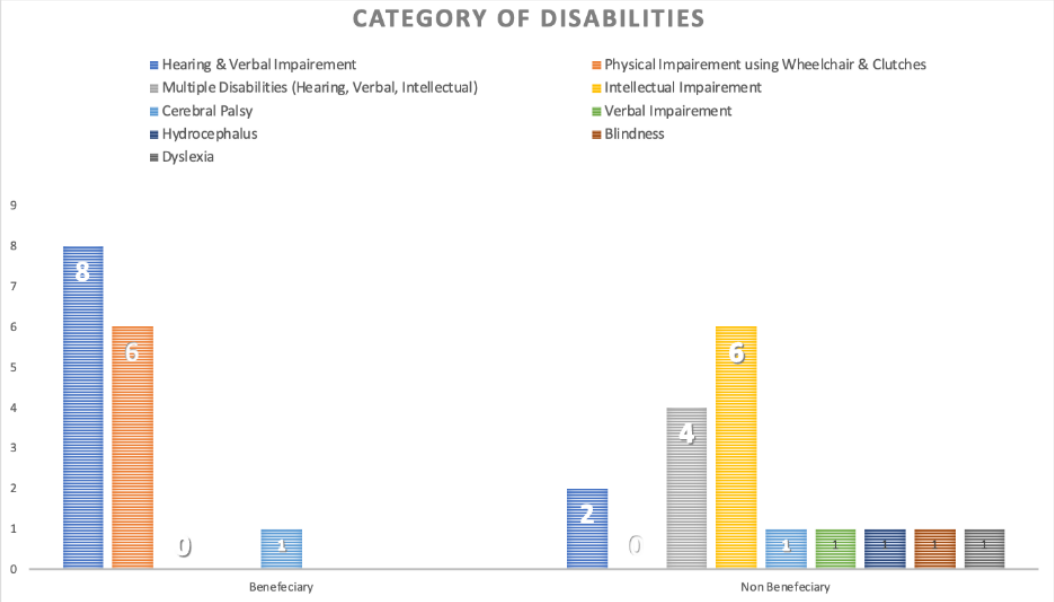


Fig 2.7: Categorization of Beneficiary and non-beneficiary based on Disability type

The responses are collected from women with diverse kinds of disabilities ranging from visible and invisible, having mobility and cognitive developmental issues. It has been noticed that women with invisible disabilities, specifically having some intellectual disability, are more marginalised in getting access to SRH and FP services. The yellow and grey bars in the non-beneficiary group represent women with the specified intellectual conditions. They are 10 among the noted 15 non-beneficiaries.

Based on the quantitative presentation of the findings, it can be mentioned that resources and identities play an essential role in transforming sexual reproductive health and family planning capabilities. However, the question is how these interact with each other for accessibility of the SRH and FP services for women with special needs. To answer the question, let us delve into the stories of the women in my next chapter.

IV. Unravelling the maze through voices of unheard

Through this chapter, I want to present the qualitative facts deciphered through the findings, which create a maze for accessing the sexual reproductive health and family planning facilities for women with special needs.

Women with disabilities are vulnerable to access to resources like finances reflected based on their education and working status for financial independence, leading them to depend on external support—resulting in them being dependent on their immediate support system, which, in the case of this research, is the family. So, to get access to any support, they first approach the family, where their support provides them with assistance based on their needs. However, those needs are being shaped and mended based on the rules set by the family's

> *Mother: "Fiona…. Come, baby, see who has come to meet you, Mzungu! Along with your favourite doughnut."*

Island of Loneliness

Fiona, a woman of 21 years of age with an intellectual disability, is staying in one of the remotest places in Kalangala district in Sesse Island, Uganda. She stays with her single Mother in a small hut, and her mother works as a domestic helper in the town. Fiona is left by her father right after her birth with her condition.

> *Mother: "I take care of my girl all alone and have never made her realise her father's absence, and she does not need a father. Men are not good; they come to us only for their needs, and they will leave us without taking care of responsibilities. Fiona was only two when we (she and her husband) learned about her condition, and what did he do? He abandoned us all alone amid this island."*

The story of Fiona and her mother is not one of a kind but rather familiar. It has often been noticed through several studies (Sentumbwe, 1995; Tanabe et.al 2015a) that the male will abandon their partner or wife who has given birth to specially abled children. They believe that giving birth to a disabled child is a bad omen from God and that being with that child and the mother will harm their life and endeavours as the superstitions persist that evil spirits possess these children.

Out of all the 32 respondents in the following research conducted across Rural areas of Kalangala District and Semi Urban areas of Kampala, most of the respondents share the same issue faced by Fiona and her Mother in each of the families the women have either been abandoned by their husband or partner or been abandoned by the father if they are young.

In a highly male-dominated society where men are the primary earning members of the household and the financial bearers of the household for economic mobility, when they leave the role, the family loses its extensive support for its daily nits and grits of the livelihood. The whole pressure comes on the woman of the house to take care of the children and their expenses. They lack protection and additional support from the state or other organisations to care for their children, especially when they have specially abled conditions. Things become way more challenging to integrate themselves at a homo sapianic level and a homo economicus level (Cruz, and Brown, 2016) if the woman has specially abled conditions; their body does not fit enough to generate capital for the economic units. The systematic subjugation of society firstly based on their gender and normative ability standards brings a curse for the family.

For Fiona, her mother means the whole world to her; she wants to be like her, taking up her role of Mother. Even if she wants to have a baby on her lap whom she will be taking care of, does she have the ability to take care of a baby? Does she have the ability to understand what is the role of Mother who is Mother? Who is a father? Most importantly, how can she be a mother?

Mother of Fiona: "She always talks about kids, loves playing with kids in the neighbourhood, and always says Mum, I want to be a mother like you. How come I can say that it's difficult for her even to get a guy, and how come she will know how to have a baby? She barely can take care of herself!"

As shown in the quantitative data previously 10 of the 17 non-beneficiaries, including the respondents from individual interviews and focus group discussions from both the sites have been respondents with some kind of intellectual disability. In all those cases where women has been categorized with intellectual disability, it has been noticed that families are sceptical about informing them about sex education and or taking them to sexual reproductive health services for awareness primarily based on belief that they are incapable of understanding regarding sex which have been commonly stereotyped within the society; however, studies which have already been referred to have disapproved the notion (Bernert, and Ogletree, 2013; Borawska-Charko, Rohleder and Finlay, 2017). A lack of knowledge, awareness, and

institutional support restricts these women with special needs to understand their full potential regarding reproductive functioning and motherhood.

Interviewer: "Haven't you considered Fiona marrying and having a partner?"
Fiona's Mother:" Which Mother does not? However, again, who will marry her? I do not believe these men…. they will come to exploit her, will talk to my innocent child, and later will leave her after having a child; my husband did the same with me, and that is how most of them do, disability is a curse, and which great man will want to put the curse on his head."
"I am already old; I don't have enough money to support Fiona if she gives birth to a baby. Moreover, I do not believe even the guy will take off the one, and I do not want my baby to see the life I have seen. It's a curse…."

Disability is a "Curse"

Debra is a 27-year-old single mother with hearing and speech impairment living with her baby and 68-year-old Mother. Debra is dependent on her old Mother financially. Who has ever imagined that the sun, which brings light to the earth through each morning, will bring darkness to her already troubled life? One morning, her mother left for work, and she woke up to clean the house and do the laundry from the previous night. She opened the door, took the broom and cleaned the front yard; suddenly, a huge figure from the corner of the tree in the yard showed up. Even before she would have called him, the figure came fast towards her, pushed her inside the house, placed his heavy hand on her mouth so that she could not even scream, and then the rest was dark all around.

When her mother came, her mouth was tied, her face was blue and heavily bleeding stripped, and the body symbolised the pain of a monstrous sexual encounter with a fisherman who came and raped her being drunk while coming back after fishing. After a few months of physical changes, Debra realised she was pregnant and could not abort the unborn as it was against their religious values. Her Mother decided to take care of both, even if that is financially humongous for her at her age; Debra was never allowed to move out of the house by her mother after this violent incident.

Mother of Debra: "These men are not human but monsters. I left my child, and what did he do? He turned her into a living corpse. He did not think about her nor the fate of my Debra. I do not want her to face this cruel world, and I will be there for her and her child until I am there."

Post this incident, Debra's Mother decided to take Debra to one of the two public health care centres in a village in the Kalangala town area, where she decided to give her birth control family planning so that even if something happens like this that will not result in her to bear a child. Debra could barely speak and understand her needs;

she consented because she believed the world was cruel. They don't want her, but few want her body for their own needs, so she finds solace in her mother and believes in her mother's decision.

For many women having a disability in Uganda, Family planning is not about planning a lovely small garden where the baby saplings will grow and will shake their head under the shadow of their parents like the sun and moon does to this earth; instead, it is about restricting the ability to stop a garden which will bloom love and emotions. For women with disabilities, bearing a child is a taboo within society as they believe they will also give birth to a child who will be disabled like her Mother and then will be left by the husband, or else, like Debra, will be forced to give birth that will bring financial problems in the house hence family planning services have been taken to restrict birth among the women with disability which has been noticed similar for another interviewee of this research.

Life tangled with conditions.

As mentioned in the study by Tanabe, caregivers are reluctant to women with disabilities being pregnant as they believe that will bring additional responsibilities on them (Tanabe et al., 2015b), which results in the institutionalised subjugation of reproductive rights of women with disabilities, limiting the exercise of their body autonomy.

Grace is a 29-year-old woman with hearing impairment living with her husband and two sons from rural Kalangala.

> *Interviewer: "Have you taken a sexual reproductive health service or family planning service ever?"*
> *Grace: "Yes, I did, twice with the support of my husband, as I cannot go alone as I can't communicate because of my condition"*
> *Interviewer: "How many times you have taken the service"*
> *Grace: "I have taken SRH service ones after an awareness campaign hosted by Philomera and the birth of my first son; I have taken birth control-based family planning twice for one year. After that, my husband and I decided to have a second child, so I stopped. However, I want to retake the injection right now, as I do not want any more kids."*
> *Interviewer: "Did your husband share the same plan?"*
> *Grace: "No, sir, he does not want me to take him to the family planning service, and hence, he is not taking me to the health centre."*
> *Interviewer: "Haven't you thought about going alone?"*
> *Grace: "No sir, because I don't have the money to reach the health centre and if I ask for that from my husband, he will not give me that. Secondly, I can't communicate without his help, and there is no one in the health centre to support me."*

Although Uganda has been known for its progressive measure to make society disability-inclusive (Rohwerder, 2020), studies have noted that access to health care service, including reproductive health benefits, are not reaching the target group as there is a lack of support or assistance to convey the treatment effectively (Mulumba et al., 2014). Due to the lack of a sign language translator, Grace is unable to depend on the system to seek her family planning needs. As a result, she has to depend primarily on her husband while her husband, the house's breadwinner, exercises his authority through his decisions. As a result, not being able to convince him is restricting her from accessing the service and finally, lack of financial autonomy is also leading to inaccessibility of the support by not being able to reach.

As per the findings mentioned above, we can notice how finances and second decision by the primary caregivers shape the accessibility of SRH and FP services; however, can we think about the other way round where the respondents own the resources to capitalise for supporting the accessibility of SRH and FP needs?

In the upcoming findings, I am going to discuss more about how financial autonomy or access to economic resources, which has been primarily figured out through this research, can increase the accessibility of the services and support of the caregiver of the family.

Way to autonomy.

Sharon, a 25-year-old woman born with cerebral palsy, working as a volunteer and social worker for an NGO working for the sexual reproductive health of women with disabilities, has finished her bachelor's in social work and is planning to pursue a master's.

> *Sharon: "Discrimination has never restricted me from pursuing my dream; I have finished my studies regardless of all the barriers. Thanks to Kathie, I have gotten the opportunity to work for her NGO, so why do I feel shy about seeking my own needs?"*
> *Interviewer: "Have you ever felt discriminated against by the health care staff or other patients?"*
> *Sharon: "Yes, I have faced discrimination by the health staff once I went to take a birth control pill. I have been asked by the health staff why you need to take birth control pills. Can you do stuff? That was so mean."*
> *Interviewer: "Indeed! Could you tell me more about the experience?"*
> *Sharon: "Well, nothing much, but I dealt with the situation well because I earned. I am not dependent like society thinks about that; I can afford my needs, and I am not answerable to anyone. Weirdly, we are looked at as aliens"*

Through the conversation, it was evident that financial autonomy gives confidence to the person because it makes her feel independent, having control over the resources for livelihood and well-being. Secondly, access to those resources is shaped based on educational status. Based on few respondents having special needs, it has been figured out that the institutions have been shaped and influenced by the normative value of abilities which leads to the ostracisation of the targeted group of the research firstly based on the ability standards and secondly, unsurprisingly, because of the patriarchal notions limiting women into the household chores.

My next respondent, Mastula, who is a single mother left by her husband, a person who can't speak, and the sole earning member in her family taking care of her old Mother and baby, is a story of success, which is an anti-thesis of the prevailing normative society.

Mastula's Mother: "When her father left us because of the daughter's condition, she was three. He was afraid he had to take care of the child, but I hoped he would be here to see how her daughter was doing."

Mastula was forced to drop out of school after primary 7. The major reason was that she was not able to cooperate with the curriculum primarily because of her condition, but later, she was home-schooled by her Mother as she did not have the resources to send her to school which could cater for her needs; however, the local NGO trained her along with few other women with a unique ability in stitching and tailoring and also provided them with Sewing machine resulting which helped her and many to start their own business which is not only helping her to live but also running her family providing financial support to her Mother and raising her child.

When Mastula was asked whether she had been to the health centre for any kind of service like sexual reproductive health or family planning, she mentioned she had taken birth control pills as she had a boyfriend, and her Mother helped her to engage with the doctor.

> *Interviewer: "Have you ever felt discriminated against in the health centre while seeking your SRH or FP needs?"*
> *Mastula: "I have never been, and I do not care because I earn money and I am not begging for support, but instead, I can ask for my support confidently, and even my mother supports me"*
>
> *To her Mother*
> *Interviewer: "May I know about the experience and the support you provided to Mastula regarding her family planning needs"*
> *Mother of Mastula: "Initially, I was sceptical about the guy she was dating; however, she knew what to do. She is independent, she has her own business, she is taking care of me*

and the kid, and hence she is responsible enough to make her own decisions, so I decided to support her; my daughter is a strong woman who is not submissive to any male."

From the above discussion, it has been noticed that financial autonomy not only plays a vital role in getting access to resources but also brings the courage and confidence for the service seeker to get the support for achieving their ability and transforming that into functioning. Here, in this case, being the earning member of the family, Mastula has more bargaining power to get access to the support of her mother. As mentioned before, financial autonomy brings a sense of autonomy.

However, the finding also suggests that most of the respondents, specifically from the focus group discussions conducted, have been noted as not being able to finish their education because of a lack of support for their ability; however, when they are trained with vocational education that has given them more opportunities to reflect their entrepreneurial nature to start their own business and earning profit out of it.

While in most of the case studies through the individual interviews, it has been noticed that lack of financial resources and the correspondents' dependency upon the caregivers results in the exercise of more authority in the decision-making of the caregiver in access to SRH and FP services which has already been reflected in the mentioned case studies too. However, the question is how the identities of the respondent's shape as a barrier and intersect with each other to get access to the services or to access and capitalise the resources for transforming their sexual reproductive health and family planning abilities into full functioning.

Although from previous discussions, it has been notified that access to resources such as income, education, through vocational training has played a significant role in getting access to family support for receiving SRH services has not been the case; following the framework of the Levesque model, it has been figured out that even after having access to the resources to capitalise on the services does not have consistently been replicated into full functioning while approaching to the system the primary identities which have been noted from the case studies are age, religion, category of disability and socio geographic factors played a vital role in the unapproachability and restricting the people from fulfilling their needs.

However, regarding discussing education, a significant factor that should be highlighted is that out of 32 respondents, 12 respondents have been notified as beneficiaries and are financially independent through the support of social networks.

While out of the 12, one person had finished her higher education, undergraduate and financially independent. However, for the remaining eleven, the highlighting

factor is that although they have not finished their education majorly due to lack of support for their abilities in the educational institute, the efforts of the local NGO Philomera Hope Foundation have played a vital role in making them understand the entrepreneurial capability of women with a disability to train them through vocational education which results in them to have access to the resources like finances and family support for improvement of their sexual well-being.

So, the answer can't be simplified by mentioning their educational status; however, the question remains: What kind of education is helping them to hold money quickly or helping them to enter into the labour market for owning capital?

Too young to discuss sex

From the responses collected from the semi-urban area of Kampala in the focus group discussion, it has been noticed that women who are in the age group of 18-25 have been restricted by their mothers even to discussing their sexual reproductive health needs; they are shut.

> *Interviewer: "Have you ever thought about having a boyfriend and having a life with him?"*
> *Rowena: "Yes, I have, but I will wait for the right time; presently, I am young."*
> *Interviewer: "Have you heard about SRH or FP?"*
> *Rowena: "Yes! I did from my friends"*
> *Interviewer: "Haven't you discussed that with your mother?"*
> *Rowena: "I am afraid because I am young, and once she informed me that I am not at a proper age to talk about guys and stuff"*
> *Interviewer: "Have you thought about asking a doctor about this?"*
> *Rowena: "I haven't, but I want to; however, I can't do that alone. I am Blind, and I need support from my mother, too, even if I have money. I have already told you; she will not help me because I am young, and even if I would have managed to go lying to her it will not help because of lack of access to support for my condition, I cannot reach alone over there."*

Moreover, in many cases, it has been noticed that women with disabilities have access to financial resources, but that has not helped them in achieving their sexual reproductive health or family planning needs; in the upcoming two cases, it has been reflected how religious values play an important in approachability to sexual reproductive products or modern day family planning methods and secondly how financial autonomy doesn't help to cater needs of all women with diverse kind of special needs, due to lack of access of support based on their need from the health care centre.

The Factor of Religion

Sandra is a project coordinator working on sexual reproductive health for women with disabilities with a local NGO from the semi-urban area of Kampala. When asked about her usage of modern-day family planning or sexual reproductive health facilities, she informed me,

> *"I am a roman catholic, based on my religious values. I am not supposed to have sex before marriage, nor can I not use modern-day sexual reproductive health products because those are not natural, and it goes against the law of nature."*

All women are equal but some are more equal than other

Besides religion, disability status is essential in getting access to the service. Even if the respondents have access to resources, they can't capitalise on those resources to access SRH and FP. It has been noticed in one case. Even though women with special needs getting access to the resources increase their bargaining power in most cases over this research, it also depends on whether their abilities can transform their ability to perceive healthcare information and their ability to seek and engage. It has been noticed from the respondents who have an intellectual disability are not able to engage with the doctors or the family is restricting them because they believe that they are not capable of becoming a mother or having a relationship with someone there have been respondents from the semi-urban area of Kampala where it has been noted that out of 8 individual responses and 6 responses from the focus group discussion , three of the women are financially independent however one is enjoying the benefit however one has already been mentioned that because of the religious values is sceptical about the service however the third person having an intellectual disability and dumb but living her life working as a tailor and she is not dependent however she affords her and her Mother's expenses however she said that her Mother said that she couldn't be a mother while asking her Mother she informed

> *"Firstly, who will marry my daughter? And secondly, she can't be a mother because of her mental condition.*
> *Have you asked her about her wishes?*
> *She knows what a mother is but doesn't know what to do to be a mother.*
> *She is like a child, but I am happy she can at least care for herself."*

Again, it has been noticed that ownership of resources doesn't guarantee access to SRH and FP resources; however, disability status also plays an essential role in the accessibility of resources. Even in the disability status, people with intellectual disabilities are the most vulnerable.

In order to understand the barriers at the service delivery level, responses have also been collected from the health care providers across the urban and rural sites; it has been noticed, however, that irrespective of the urban-rural differences, the service providers here, in this case, the health care centres are not well equipped to support the standard needs of the women with special needs however the assumption regarding the biases of the health care providers to the specially-abled group has not been noted through this research, however in the case of my study it has been noticed that the health care providers are more than willing to support the needs of the women with a disability however they do not have sufficient training or necessary means to support to cater the targeted population's sexual reproductive health needs.

Interviewer: "Have you provided services to women with special needs?"
Health-care provider: "Yes, I have"
Interviewer: "Have you faced any difficulty in it?"
Health-care provider: "I have often faced it; for example, if someone is deaf or hard of hearing, I try my best to communicate. For example, once a couple came, both having hearing issues, and the wife was dumb, none of them could communicate; they were being accompanied by a translator or else it would have been difficult for me to explain."
Interviewer: "Is any support or facilities available for the healthcare staff to work on this issue"
Health-care provider: "No, not at all. We either have to find our solutions or if the patient is bringing their translators; however, you know, there is a concern about privacy; there have been times when the translator has leaked information, which goes against our ethics."
Interviewer: "Does the government mention specific guidelines to the public health care centres for supporting the specially abled group?"
Health-care provider: "No, not at all; the problem is for the government. Working for the specially abled group means building ramps; however, it is something more than that. What about those who cannot see, hear, or even intellectually disabled? They are sometimes restless, and we are not trained to diagnose them."

From the discussion, it has been noticed that the doctor, although he does not have a personal bias against the disabled group, and for him, every patient is equal; however, the available resources provided by the government are only meant for people with normative abilities; hence that is making it difficult for him to cater their needs.

Besides, there have been responses taken by enthusiastic doctors about the unique needs of women with disabilities. It has been figured out through the finding that doctors have made special efforts like counselling services in supporting the sexual well-being of women with special needs.

Interviewer: "As you said, you provide exceptional support for women with special needs. Can you share how you help them?"

Health-care provider: "You know these women are vulnerable and innocent and suffer from self-doubt about their bodies and abilities. These vulnerabilities have often been taken as an opportunity to exploit. Guys will manipulate them, and then after fulfilling their needs, they will leave her alone, so I usually talk to the girls, telling them to wait for the right person and not believe in someone; just like that, you are not different, you are special like anyone else."

Way beyond 'Ramp'-ification is needed

It has occasionally been observed that despite government efforts in healthcare facilities to provide assistance to people with special needs, those efforts are not well suited for a range of disabilities. However, they provide for the needs of particular categories of impairment, which can be broadly characterised as visible disability with mobility concerns.

Interview: "I am noticing that the government has taken measures to support people with disabilities by building ramps"

Health-care provider: "But that is the only measure taken; building ramps does not only help. Some people are deaf and dumb. What are they going to do with the ramp?"

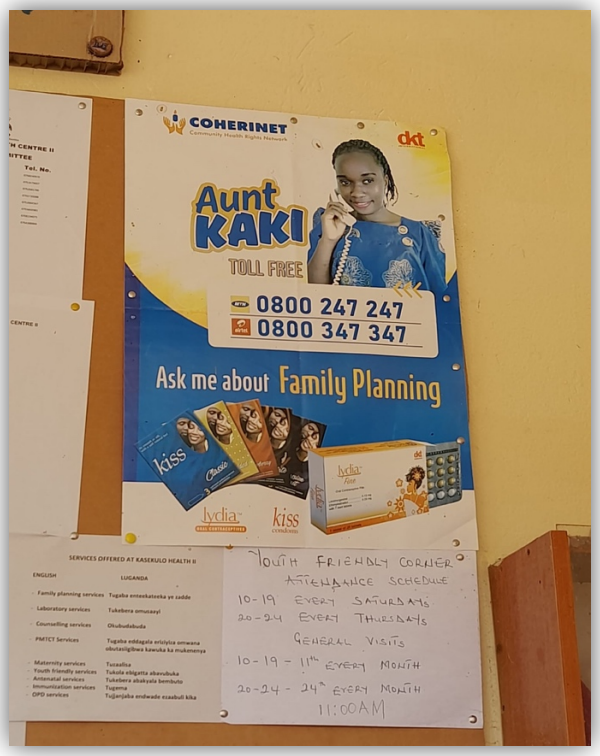


Fig 3: Awareness Poster in Health centre for Family Planning

Source: Author

Reference has been drawn from the above poster by the health care professional informing that the awareness posters are not disability friendly, leading to a lack of communication and information gap for women with special needs.

It has been noted from the following remark of the healthcare professional that, despite the fact that steps have been taken, they have homogenised disabilities into a single sort, leading to a lack of assistance for various needs regardless of other disabilities.

Although it has been found that public health centres are not equipped with facilities to cater to diverse kinds of special abilities, healthcare professionals individually have made special efforts to make the services available to women; however, health centres which the church runs do not provide modern-day contraceptives which goes against the religious values, it has been noticed at times since the government health care centres are far from the service seekers in that case the only option for them is get affordable service in remote areas are the church-run health centres however due to the unavailability services they are not receiving the health care services.

> *Interviewer: "May I know what are the services being provided from the health centres for SRH and FP?"*
> *Health-care provider: "Yeah we do provide those services which are natural"*
> *Interviewer: "Can you explain a little bit more about what is natural"*
> *Health-care provider: Natural, means we don't provide condom, contraceptive pills etc, all those are messing up the natural course of reproduction most importantly are against the Christian value and see we are church run health centres."*

However the stark contrast between the high number of beneficiaries in Kalangala compared to Kampala is not only limited to the accessibility of the resources however the socio geographic status also played an important role in setting up the tone for the beneficiaries to voice out their needs. In multiple occasions through several informal conversation and informal interviews with the service seekers, local people and service providers it has been noticed that people in Kalangala is quite liberal to discuss about sex. Even in another study, it has been noticed in the finding that sexual acts without privacy has been normalized leading to ease of having sex talk even within families irrespective of age difference (Kwiringira, Mugisha, Akugizibwe, and Ariho, 2021).

The findings have suggested that access to sexual reproductive health care and family planning needs primarily depends upon access to the resources which transforms

the abilities of women with disability to achieve sexual reproductive and family planning well-being; the significant resources which have been figured out through the collected responses is that financially independent women are more prone to receive social support because it creates a sense of autonomy however it has also been noticed that access to resources doesn't guarantee their health care needs, their identities act as an intersecting barrier to get access to the service which has been discussed before that is age, religion and disability status, however even within disability status it has been noticed that among diverse kind of disability women who are suffering from intellectual disability are the most marginalized who are being assumed to be considered as incapable of having child or being in a relationship.

V. Discussion: Threading theories to empirics

Out of the mentioned ten fundamental themes of capabilities listed by Martha Nussbaum to achieve well-being, the analysis of the research findings has focused on the theme of Bodily Integrity. The ten central capabilities listed by Nussbaum are not implied to be innate human traits; rather, they are facilitated and shaped by the social context in which a person lives (Nussbaum, 2000). However, in less-than-ideal circumstances, the social context tends to meet the needs of the majority while marginalising few needs, which limits one's ability to achieve if the person is coming from the marginalized category. The capability approach focuses on the structural conditions which limit the opportunity (Robeyns, 2005) for the target group in the research to get access to the SHRH and family planning facilities.

To discuss specifically about Bodily Integrity, first, we need to delve into the definition of the idea. As Martha Nussbaum has mentioned, Bodily Integrity is "Being able to move freely from place to place; having one's bodily boundaries treated as sovereign, i.e., being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction." (Nussbaum, 2000, P 78)

To assess whether the targeted group of this research can integrate their needs related to reproductive matters and sexual satisfaction to transform their SRH and FP capabilities, the data has been assessed and analysed through the matrixes for transformation of capabilities. As Robeyns has mentioned in her article, "The focus on capabilities does not deny the important contribution that resources can make to people's well-being. Indeed, resource inequalities can be significant causes of inequalities in capabilities and therefore also need to be studied" (Robeyns, 2003, P 64). It has been figured out through the study that access to resources plays a significant role in the transformation of capabilities; however, other work by Robeyns have also mentioned that although resources play an essential role in the achievement of human well-being, the focus should also be there regarding the intrinsic matters for capitalising those resources for the transformation of capabilities (Robeyns, 2016). Hence, resources alone cannot answer the issue. As it has been mentioned again by Robeyns, people differ in their ability to transform resources into capabilities based on several factors (Robeyns, 2017, p 45).

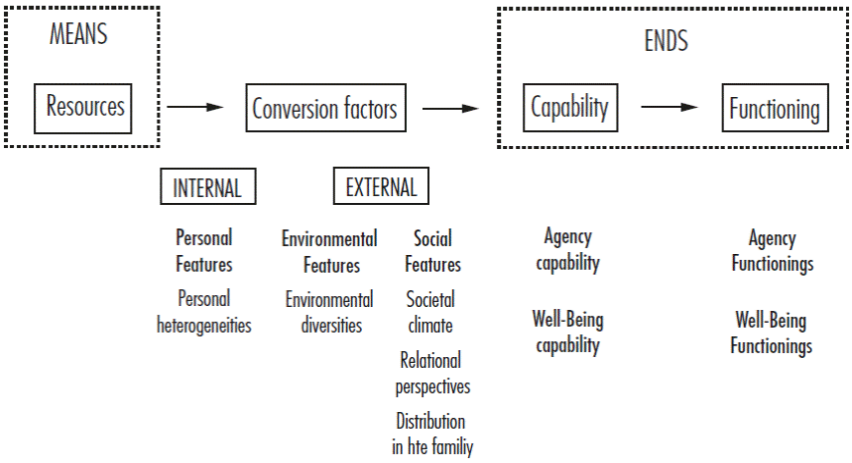


Fig 4: Transformation of Resources to Capabilities & Functioning

Source: Garcés, 2020, p-200

As mentioned in Nambiar's piece, for an individual, social factors play an essential role in making those resources effective and transforming capacity building for effective functioning. Institutions have primarily shaped society, and institutions set the rules of the game of society (Nambiar, 2013) just like putting meaning into alphabets, stitching them together to form a word through norms shaped by identities, geography, and many others. These norms set through institutions act as a conversing factor to make those resources effective for transforming capabilities. Even through my study, it has been noticed the same; hence, I will dig deep into those conversing factors and how those influence the transformation of the capabilities.

Connecting the thread of the mentioned capability with the target group of this research, it has been noticed through the finding that in most of the cases women with special needs are not being able to explore their capabilities for sexual satisfaction and exercise their autonomous choice in their reproductive needs. However, those women who are being noted as beneficiaries and being able to explore their SRH and FP capabilities and transform them into functioning, they are being guided through means and resources to achieve the ability to integrate themselves with the prevailing service structure provided for SRH and FP needs. So first will try to figure out what are the means or resources exerted from the finding which plays a significant role in transforming capabilities and to understand the transformation of capability into functioning, focus should be made on the conversing factors.

However, the question comes of how resources and the conversion factors have been figured in getting access to the SRH services; for that, the responses have been assessed at the different levels of the service-seeking and service-delivery level based on Levesque's healthcare model (Levesque, Harris, & Russell, 2013).

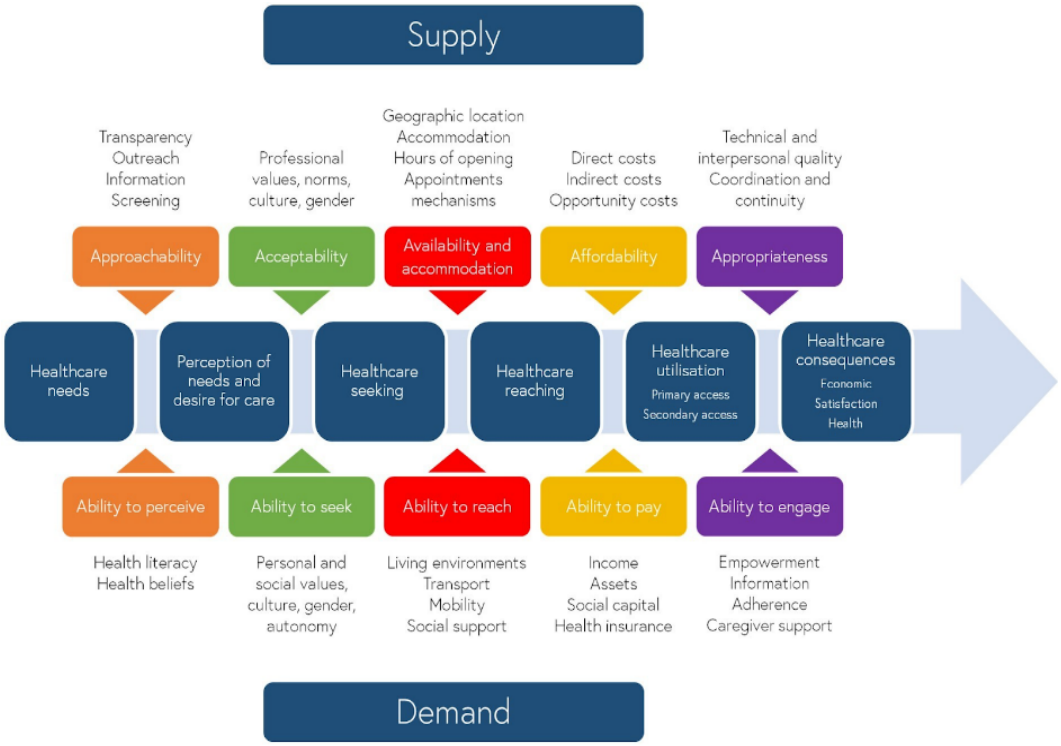


Fig 4.1: Diagram of Levesque Framework for healthcare access

Source: FutureLearn

To understand how resources, accessibility of resources, and factors transforming those resources into capabilities of sexual and reproductive health and family planning abilities and how they influence the outcome for achieving sexual and reproductive well-being in life, this study connects the responses with Levesque's health care model from the supply and demand side matrixes. With an emphasis on the diagram above, each response has been gathered and examined separately at different stages, as portrayed in the blue boxes in the mentioned diagram. The examination has been staged, beginning with exploring requirements for FP and SRH facilities and ending with the transformation of capabilities to meet those demands, leading to the attainment of well-being as depicted in the integrated image below.

Fig 4.2: Diagram of Integrated Analytical Framework of the research

Source: Author

V.I Resources:

V.I.I Finances are catalysts for change.

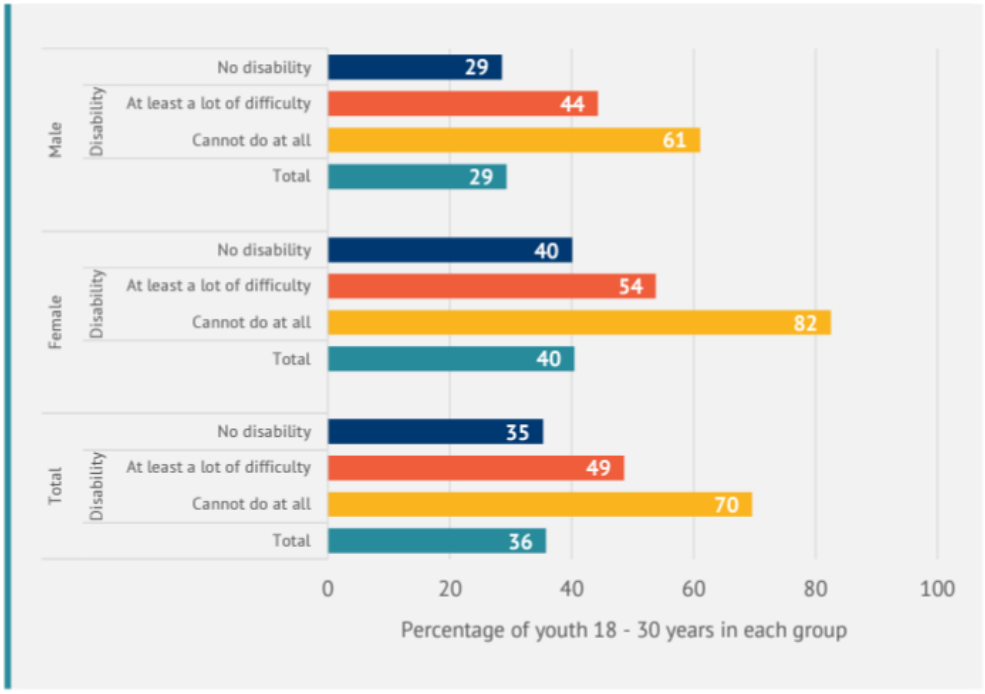
When women are financially independent, they are bold enough to not only express their needs but also transform them into capabilities through control over resources to full-functioning, here in this case, like income or sewing machine to receive income, when the woman earns and contributes financially to the household finances, that guarantees support from their care providers and other family members, as has been noticed in few of the cases from the findings.

Emmet and Alant have mentioned in their article that the income status of the household with a member having a disability is essential in the vulnerability matrix. A family where every member is working, including the person with a disability, is less vulnerable than a family where they are dependent on the earning member (Emmett, T. and Alant, 2006). However, the question lies in why family support is shaped by financial independence in the case of the study. It has been noticed that there is a perception among the family members that if their woman gets impregnated, they will be eventually left by their partner, which will result in added responsibility for the child. However, if the woman is financially independent, there are possibilities of taking care of the child, which gives more confidence to the caregiver. The children add to the equation of vulnerability, too, resulting in weak economic positions of the family overall. Hence, to minimise the expenditure cost, the earning caregivers of the family exercise their authority and supersede the autonomy of women with special needs.

So a simplified look at the quantitative data from the findings will express that financial resources act as a significant factor to make the grade of reproductive well-being; in this case, financial resources mean earned income shaping financial freedom. It has been seen that women working outside the home and earning money improves the situation and expose her to new information, resulting in exercising her autonomy (Osamor & Grady, 2016).

However, in the present case scenario, through recent government-released data, it has been noticed that Women with disabilities are more vulnerable to joining the labour force and becoming financially independent as they are not employed or trained for it which increases the risk for their vulnerability (Ministry Of Gender, Labour And Social Development, 2020, p-75). Improving financial independence status needs to be addressed in general as empirical evidence has shown it leads to improved health and well-being of people with disabilities in common (Jang, Wang & Lin, 2013)

Figure 48: Percentage of youth 18-29 years who are not in employment, education or training (NEET), by disability



Source: Based on own calculations using Disability Situational Analysis Household Survey 2019

Fig 5: Data on unemployment rate of people with disability in Uganda

Source: Ministry Of Gender, Labour And Social Development, Uganda, 2020

Through this study also, it has also been noticed through the findings that women with special needs who are getting access to financial means through income can

afford the direct and indirect costs of accessing SRH and FP services. Alternatively, they depend on their partner or family members for support. However, when dependent on their family or partner, they have limited choice to exercise their autonomy to voice out their needs. Based on the virtue of caring responsibility through the ownership of primary resources to transform their capability of SRH and FP needs into functioning, here, in this case, finances, the family members or partners impose their decisions upon them.

As in one of the cases, it has also been found that the care giver husband has taken the decision of family planning as he is the earning member and the woman is not being able to voice out her needs and reach for services as the translation of services are restricted to her husband on the virtue of being a caregiver financially. So, in the absence of an accommodative service structure, finances act as a catalyst for transforming the capability of family planning needs into effectivity.

Having physical conditions to get access to the service makes women dependent upon their husband or partner. When the partner is earning and taking care of the needs of the woman, they enjoy more authority; hence, we can say access to financial resources plays a vital role in putting forward the autonomous choice of a woman.

V.I.II Education & Vocational Education is the key to finances

Now, the question is how the accessibility of independent financial means is shaped. The question lies in the quantitative enlisted finding, i.e., education. We can notice through the findings that to bargain with power structures, the component that improves their bargaining power and acts as a factor to improve their bargaining power is education, which is a significant factor in making an informed decision for themselves. Moreover, because of education, there is an enhancement in employment opportunities and an improvement in their capacity to deal with service providers. Entrance of women into the labour market has been shown to lead to freedom of mobility, respect in household and community (Juraqulova and Henry, 2020)

Moreover, discussing further about the education resources to enter into the labour market for ownership of capital, it has been noticed through the research that many participants because of lack of accessibility of economic and social support to pursue and finish formal education when have been trained in vocational training courses have a high prevalence of getting access of income capitalising on their developed entrepreneurial skill. This income leads to the accessibility of the SRH and FP services, it has been noted through a study that through vocational training there is an increase of employment opportunities for women with special needs (Jang, Wang & Lin, 2013).

V.II Personal, Social & Environmental conversion factors shaped by Identities & others restrict the resources from transforming into capabilities:

However, the question remains through the findings that even after the accessibility of the noted resources, specifically financially shaped by education and vocational education why still, services are not guaranteed to the women with disability in every case. There is a thin blind between the service seekers and the resources to transform their capabilities of SRH and FP into full functioning. As previously indicated in reference to Nambiar's study, resources by themselves cannot transform capabilities; instead, they require help from a number of inherent social elements which act as conversing factors (Nambiar, 2013). According to the Capability approach theory, these opposing elements have an impact on a person on three different levels: the personal, social, and environmental levels (Nambiar, 2013, p223). The same thing has been observed throughout my research, so I will delve deeply into the components at these three separate levels and how they affect the development of capabilities.

It has been noticed that there is a significant intersection of identities and resources in shaping the accessibility of services at the personal level. As (Milles, 2019) has mentioned from other studies, "intersectionality argues that multiple axes of power and difference shape each other and that people with multiple subordinate identities experience oppression singularly and simultaneously, depending on the context" (Collins 2000; Schulz and Mullings 2006; Thornton Dill and Zambrana 2009). Here, in the case of the study, multiple marginalized identities, such as the disability category, being a woman creates an added constraining conversing factor against the accessibility of SRH services. Through empirical data, "Feminist disability theorists essentially view women with disabilities as having a position of double vulnerability. This approach directs attention toward the fact that women with disabilities live in a society that is at once disablist and patriarchal" (Curry et al., 2001; Thomson, 1994), as mentioned by Brownridge in his article (Browridge, 2006, p 808). As a result, the intersection of identity is a significant factor that significantly impacts their daily lives for achieving well-being.

V.II.I Personal Conversion Factors:

I. Category of Disability:

Here in the case of my study, it has been noticed from the findings that kind of disability plays a vital role in the accessibility of service at a personal level. Suppose

we widely categorise the diverse special needs. In that case, it has been noticed that visible disability needs support to bridge the communication gap between the service provider and service seeker due to the lack of infrastructural support from the service provider end. Due to the lack of support, the family plays an essential role in translating their needs; however, that support is not unconditional. As mentioned before, access to finances plays a vital role in receiving unconditional support, resulting in a completely autonomous choice to move out of the house and be able to afford the direct and indirect costs such as commuting and paying for the reproductive necessities. However, it has also been noticed that women with a cognitive disability, more specifically with an intellectual disability, are more marginalised than others, even after gaining financial freedom. Because of their condition, they are considered childlike and incapable of taking responsibility; social norms regarding the type of disability play a vital role in guaranteeing access to family support. Family plays a vital role as an agency to shape the needs and resources to transform into capabilities; however, based on prevailing norms regarding intellectual disability, family is not supporting their needs. It has been believed that women with intellectual disabilities cannot select partners. They can be manipulated, which can result in sexual harassment and assault, which can often lead to the birth of a child through unwanted pregnancies; moreover, it has been assumed that they are incapable of taking care of themselves, so they will be unable to take care of a child. However, several studies have shown that if there is proper sex education provided to people with intellectual disabilities, they will not only be conscious about sex but also reciprocate sexual acts (Bernert, and Ogletree, 2013; Borawska-Charko, Rohleder and Finlay, 2017). Similarly, study have also shown that motherhood brings change as per their physical changes, which makes them understand their kids (Mayes, Llewellyn and McConnell, 2011); however, they have been stereotyped within society as childlike, which has been reflected based on several occasions from multiple interviews with the respondents resulting to restriction to explore about their sexual needs and taking support for that. So, disability status is shaped based on the social norm prevailing, specifically regarding intellectual disability, which influences the communication and social support chain to transform capabilities.

II. Age as a barrier at an individual level:

Besides that, accessibility of the resources at the personal level is also shaped by age. However, women have reached adulthood, but if they are not working, not studying or engaged in the middle of a vocational or any other educational training and are dependent on family at that time, the family has become protective of the women or daughters with disabilities in the house. They believe they are novices to discuss sex, leading to restrictions based upon familial conditions for accessing finances. As per the family, they can be exploited easily by another gender group here, in this case, males, as they are worried that knowledge about sex can lead to exposure to sexual contact. Findings from studies conducted in lower middle-income countries have shown that "single and young woman with disability have limited knowledge

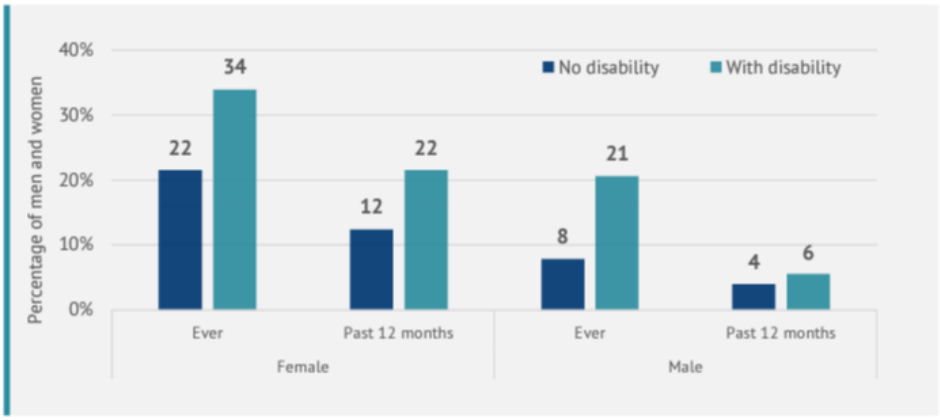
about SRH and FP and they are shy to express their SRH" needs (Matin et. al, 2021). Study focusing on the similar theme have shown that at times they also have to prove their family through necessary qualifications as condition to get support for planning a family (Dean, Tolhurst, Khanna & Jehan, 2017a).

V.II.II Social Conversion Factors:

I. Age as a barrier shaped by notions of Patriarchy:

To go deeper into the protective attitude of the family, we must examine patriarchal control (Dean, Tolhurst, Khanna & Jehan, 2017b) over the sexual requirements of the body of women with special needs in order to exercise their autonomous choice for accessing SRH needs. As the prevalent concepts inside society have evolved, males are absconding over the bodies of women with special needs in order to meet their sexual desires. It has been noticed through, study that unstable romantic unions of women with special needs are widespread in Uganda (Bantebya, Muhanguzi & Watson., 2014). Besides that, teenage pregnancy has also been a concern (Kwagala & Wandera, 2021). Cases including this have shown that women with special needs have been sexually assaulted, leading to unplanned pregnancies (Plummer and Findley, 2012), which also restricts the curtailment of educational prospects of women with special needs, leading to financial dependency (WHO, 2007). It brings a financial burden on the family or caregiver and leads to social ostracization based on the stigma that children of women with special needs are a bad omen. These lead to a protective attitude among the family. As per government data from Uganda, Women with disabilities are more vulnerable in cases of sexual assault who have been abandoned and been abandoned by opportunistic males (Ministry of Gender, Labour and Social Development, 2020, p-56).

Figure 28: Percentage of men and women that have ever experienced sexual violence and in the 12 months preceding the survey



Source: DHS 2016

Fig 5.1: Data on experience related to sexual violence among people with disability in Uganda

Source: Ministry Of Gender, Labour And Social Development, Uganda, 2020

Moreover, there is an inherent family belief that it is unnatural for a guy to accept a woman with special needs as their partner. If they are coming, they are coming with an agenda, so they are worried and sceptical about supporting sexual needs with the belief that they can be exploited. An empirical study based in India related to the accessibility of SRH facilities for women with special needs has shown that family members of young women above 18, even after reaching adulthood having some disability, have been protective of them, which at times limits their autonomous choice to select a partner and also exercise their sexual autonomy based on the belief they might be deserted later. (Dean et al., 2017) Here in this study, a similar trend has been noticed. Due to the protective character of the family, all of these factors culminate in young women between the ages of 18 and 25 who lack access to capital and are unable to exercise their autonomy over their sexual or reproductive demands once they reach adulthood. The financial assistance is mostly provided by family, which is crucial.

II. Family bridging the gap between service seekers and service providers

While discussing the resources and the personal factors acting as a conversing factor, there is simultaneous mention of the Family. The Family is the primary caregiver to women with special needs. It is the first point of contraction to transform their needs into capabilities through proper support through finances and communication with service providers or other forms of miscellaneous support such as accompanying while commuting, etc.
Studies have shown that "people with developmental disabilities, family members, usually parents, are the backbone of their community support system, often serving as an alternative to institutionalization" (Freedman and Boyer, 2000).

Family as the social support and the primary caregiver plays a necessary role in helping to connect with caregivers and care seekers. This empirical study has explored that a supportive family as social support plays a vital role in converting reproductive capabilities in the absence of infrastructure at the health care centres, for example, sign language support, lack of support to reach the health centres due to lack of transport facilities the women with special needs face difficulty at the service delivery level which affects their ability to reach and ability to engage with the health care professionals accessing based on the Levesque health care model; as a result, there is a void has been created.

Family support has filled the gap. However, that support has not been unconditional. That has been influenced by conditions shaped by resources, majorly in the form of finances, more specifically in the form of independent income by the women with special needs. Moreover, approaches shaped by the social norms regarding supporting the reproductive needs of women with special needs have also been a factor in shaping family support, which has been discussed before.

III. Religion:

Furthermore, religion at a societal level also plays a significant role in shaping the personal values of a person influencing SRH needs; studies based on sub-Saharan Africa have mentioned that religion plays a dominant social factor both at service seeking and service delivery level for the accessibility and fulfilment of SRH and FP necessities (Jonas, Crutzen, van den Borne, et al., 2017). Sex beyond reproductive purpose or restricting reproductive purpose is considered a sinful act which restricts their ability to seek SRH and FP needs at a personal level of the beneficiary and also acts as a barrier at the service delivery level, shaping the environment for accommodating diverse sexual needs beyond reproductive purpose. Here, in the case of the study, it has been noticed that even after accessibility of resources, the personal values shaped by religious belief limit their ability to seek SRH and FP services, which notes that accessibility of resources and a robust support system does not always guarantee SRH and FP services personal values shaped by religious identity also restricts to capitalise the resource. Furthermore, it has been discovered via interviews with service providers that healthcare facilities administered by the catholic religious institutional value limit the acceptance of cases relating to SRH and FP requirements, which move beyond the fold of religious values. As a result, religion serves as a strong social catalyst in determining the wants and availability of services, as well as a prominent limiting conversing element for capitalising resources for accessibility of SRH and FP facilities.

IV. NGO as the guiding light towards the key

Here, in the case of this study as mentioned before in the rural area of Kalangala, one of the primary reasons for the financial independence is that vocational training courses. These courses have been facilitated by the respondents with the effort of the local NGO Philomera. It has been noted and observed through informal interviews with the NGO project officers and local administrators, i.e. the village head has taken proactive measures for the outreach of government lead vocational training courses to the women with special needs in the village. Moreover, the women have been provided with primary capital to set up their entrepreneurial setup, like a sewing machine for tailors. Hence, the NGO team played a significant role in social support for accessing women with special needs with vocational education

shaped to own financial resources. Empirical studies have also shown that social support through NGOs leads to the improvement of the financial autonomy of women, leading to a spilling effect on the health and well-being of women through broadening measures to take care of health care needs, reducing the burden from the caregiver (Alamillo & Diaz, 2012). The following theme has also been reflected in the conducted study too.

V.II.III Environmental Conversion Factors

I. Lack of Infrastructure Restricting the supply side

From the findings mentioned earlier from the conducted research, it has been noticed that in the world of normative standards of ability, few bodies are stigmatised based on their different standard of ability. Stigmatisation is not limited to social interaction; however, stigmatisation is also shaped by the infrastructures built in a normative form. Before discussing resources figured through the findings and the barriers to accessibility of resources to enhance the ability of SRH and FP health, first, we need to delve into the support structure and why people with special needs need to have extra support for the services at their own cost however people with normal ability could get it quickly. As it has been mentioned in Mandelov's study, all humans need infrastructure support for daily life activities; for people with special needs, the infrastructure meant for them is devalued on a societal level or completely unrecognised and invisibilised, resulting in stigmatisation of dependency (Mladenov, 2016).

Here, in the case of my study, women with special abilities are not only being stigmatised in person within the society at times; however, they are being stigmatised by the infrastructures built with normative notions, in this case, accessing SRH and FP services and their direct and indirect costs such as travelling to the health centre, being able to communicate individually to the health care professionals where the services are being catered only for specific ability leading to the non-accommodative environment for the service seekers. Hence, they must keep themselves at par with the available infrastructural support and other services to fulfil their needs. For that, they need the support of resources to enhance or maximise their ability to access the prevailing services meant for SRH and FP needs.

However, it has also been noticed that even if measures have been taken from the government's end, they have homogenised the category of disability. As it has been mentioned by (Philip,1990) in his article from an empirical case study that society has culturally appropriated a particular kind of handicapped behaviour as a good cripple resulting in specific support for them or accommodating their needs in the prevailing infrastructural support. This ideology results in the creation of marginalised within the disability group, which has also been noticed through the research.

II. Socio geography matters

Moreover, socio-geographic locations play an essential role in the accessibility of the services, as it has been mentioned in the findings that people in Kalangala are more liberal in talking about sex. However, on the one hand, although Kalangala is noticed to have an open culture to talk about, it is followed by several unwanted reasons, such as a high unemployment rate, low education rate and poverty. (Kwiringira et.al, 2021). This socio-geographic nature acts as a double-edged sword, which increases the vulnerability of women with special needs to exercise their sexual and reproductive autonomy freely. As mentioned earlier, because of the paternalistic attitude towards them, the family members treat them as child-like; in one of the cases, it has been noted that the respondent having an intellectual disability has been sexually assaulted, resulting in an unwanted pregnancy. This led her to take family planning service after giving birth to the first child without complete understanding or consent but instead as a forced measure by the family member to protect her from further unplanned pregnancy. Moreover, the unstable unions have created a perception regarding men coming to Kalangala that they come for their sexual needs, and the body of a woman with special needs can be easily accessible as they cannot protect themselves. This perception has also been reflected in the case study referred to.

However, it has also been observed that proactive measures through several awareness campaigns through local NGOs and government initiatives and the free distribution of condoms at every health centre have led to an awareness among the respondents to have safe sex and proper usage of SRH and FP resources, resulting to reduction of HIV rates. (Mukasa, 2022) Based on that, it can be believed that rigorous HIV awareness campaigns, messages and posters in health centres, which have also been noted, can also make the respondents aware of having safe sex if they are equipped to access those resources and aware of their needs. However, in the case of Kampala, people are more restrictive to discuss about sexual needs.

VI. Conclusion

The research has been followed up based on the hypothesis that there is a failure for women with special needs to integrate their bodily needs related to sexual and reproductive well-being.

The hypothesis has been resulted from the negative perceptions of society about SRH and FP needs of women with disabilities that are shaped by cultural norms. However through this study it has been found that beyond cultural norms , to meet

demand-side requirements for SRH and FP, resource accessibility is crucial. The access of resources such as finances and education lead to the improvement of the wellbeing status moreover leads to the development of exercise of autonomous choice. In the present case scenario, as mentioned through previously referred government data and this empirical study, the targeted population is highly vulnerable to access resources, leading to the poverty.

Hence, focus needs to be made on the capacity support for the overall development of the targeted group in general beyond their SRH and FP wellbeing.

Additionally, it has been observed that service is only sometimes guaranteed, even when resources are available. The ability to capitalise on such resources for converting SRH and FP-related capabilities is affected by several elements, including identities, socio-geographic characteristics, and social support.

Based on an empirical study, it has been noticed that current healthcare policies and infrastructure assistance need to meet the varied demands of persons with special needs; instead, they have homogenised the targeted population based on only a few of their abilities, among many. As a result, policies must provide the targeted population with infrastructure assistance tailored to their needs.

In addition, initiatives for the demand side must be taken to build the capacity of the women so that they can express and transform their SRH and FP needs into capabilities. This study has shown that when women with special needs can access income through capacity building, it gives them more opportunity to exercise their autonomy to reflect on their needs and transform their capabilities related to SRH and FP. Local NGOs play a significant role in assisting in this capacity-building effort. However, the solution is not monochromatic; it has several other tints. Besides resource support in the form of income to afford the services, they also need to gain the family's support as a medium of assistance in getting to the health centre on the supply side, as there is a vacuum for supporting individual necessities.

In addition to that, policymakers need to take individuals' religious beliefs and values into account when crafting policies to support the demand for meeting the sexual and reproductive health necessities of the specially abled population. Religion is a powerful force that speaks to and leads the people. Since the current facilities do not concentrate on the intersecting factors at various levels preventing the transformation of capabilities, it can be concluded from the study that there is no universally applicable solution for improving the accessibility of SRH and FP facilities for women with special needs. Hence, the prevailing model needs to be more individual need-based, focusing on intersectional unique barriers rather than being generalised.

VI.I Limitations of the paper:

This research has been part of the bigger Breaking Down Barriers project, initiated by Lillaine Fonds in 2015 in different parts of sub-Saharan Africa, to understand the barriers faced by women with disabilities to get accessibility of SRH and FP services. Uganda has been part of the focus among one of the other countries. However, the study has been limited to the populace of women with special needs from couple of sites of the country. However, to have a broader overview of the significant population, the focus needs to be addressed across identities like gender, diverse ethnicities, etc, from other parts of Uganda. Moreover, although the responses have been collected from diverse disability categories however many women have been opted out of the interviews who are not been part of the local NGO network.

However, being part of the MA candidates' research paper, time and resources were limited for extending the research. To obtain a more dynamic image of FP's and SRH's accessibility, things need to be compared with the normative populace and men with disabilities. Moreover, it has been noticed that there is a trend of taking birth control-based family planning services among women with disabilities; however, due to limited resources, things could not be followed up and confirmed on a grander scale.

VI.I.I Research can be followed up:

There is still more research that needs to be done following the gap in the study focusing on the unfolded identities, such as male-female, normative abilities, and varied ethnic groups through categorization. Furthermore, it also needs to follow up on the issue of the high prevalence of birth control-based family planning among women with special abilities.

Funding of the research:

Being part of the bigger project of Lilianne Fonds, this research has partially been funded by the organization.

VI.II Policy recommendations:

Supply-side:

Long term

- Ramping up the infrastructure of roads and commutes for easy outreach
- Decentralising the health care structure through the establishment of mobile clinics.
- Outreach to the targeted group through campaigns for SRH and FP specially to their families for demystifying perception related to disability.
- At the community level, outreach activities must be accessible in accordance with individual requirements, just as policies for SRH and FP must be formulated and accessed according to individual needs.
- Integrating faith-based organisations and engaging in negotiations with them to satisfy the population's requirements for FP and SRH.

Mid Term

- Training the health care professionals based for the people with special abilities.

Short Term

- Village Health Team professionals in rural areas and a similar team or medical interns in urban area can be roped through remuneration in facilitating the services at the community level

Demand side

- Capacity building through vocational training
- Providing primary capital to support initiatives of women with special needs to enter into labour market either through government or NGOs.
- Providing comprehensive sex education to the women along with the family for awareness
- Roping in NGOs to support community-level interventions from the Government.

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Annex 1. Draft Semi-structured Interview Guides

Service provider staff

Gender: _____
Age_____
Experience (number of years as family planning agent) _____
Organization of service: _____

1. Which national policy, law, or framework on SRH & family planning exists in your country?
2. Do the laws and policies on SRH & family planning discuss the provision of SRH & family planning to PWDS?
3. If your answer is yes to the question above, explain what specific information the policies contain for PWDS.
4. How do these instruments address sex education, contraceptives, and informed decision-making about family expansion, especially for persons with disability?
5. What SRH & family planning services do you provide?
6. Who is your clientele/ who do you provide services to, and do they include PWDS?
7. How do you provide your services to PWDS?
8. Which areas are used for the provision of SRH & family planning? centers, mobile clinics, etc.?
9. Do PWDs seek specific SRH & family planning services? If so, which are the common services sought?
10. Do PWDs have equal access to your services in comparison with able-bodied individuals?
11. If your answer to the question above is 'yes', how do you know that they access family planning on an equal basis with others?
12. which type of disability accesses family planning more and why? which one is the least disability to access family planning and why?
13. What do you think are the family planning needs, attitudes, and beliefs of PWDs on using modern family planning methods?
14. What are the reactions of other service providers when a PWD seeks family planning?
15. Which gender among PWDS seeks more family planning than the other? Male or female?
16. Give reasons for your answer above.
17. What are the barriers and opportunities to access to SRH & family planning services for PWDS?
18. How often do you encounter individuals with disabilities who express a desire to become parents?
19. In your experience, do you believe that the desires of individuals with disabilities to become parents are taken seriously by society?
20. Have you ever encountered a situation where a need expressed by a person with a disability was not taken seriously? If yes, please describe the situation and the impact on the beneficiary.
21. Are you aware of any specific barriers or challenges that prevent individuals with disabilities from seeking and accessing sexual and reproductive health (SRH) services?

22. Do you offer specialized SRH services or support for individuals with disabilities, such as accessing information, adaptive equipment, trained staff, or anything specific?
23. Are there specific services for STDs (sexually transmitted diseases) that are designed to address the needs of individuals with disabilities?
24. How would you rate the inclusivity and accessibility of your SRH services for individuals with disabilities?
25. Are there any specific measures or initiatives in place to promote SRH and motherhood support for women with disabilities?
26. What improvements or additional support would you suggest to better meet the particular demands of individuals with disabilities in the context of SRH and motherhood?

27. Do You think the types of disability determine barriers and opportunities to accessing family planning?
28. How often do PWDS come for family planning services?
29. Which specific family planning does each gender of PWDS seek the most?
30. What strategies do you use to encourage access to family planning for PWDs? Which strategies you use have proven very successful and why? Which strategies have proven the least successful and why?

Beneficiary PWD

Gender: _____
Age range: 18-30
Marital status: _____
Ethnicity: _____
Religion: _____
Highest educational level: _____
Occupation: _____
Category of disability: _____
Possession of disability card: Yes. _____ No. _____

1. What national policy, law, or framework on SRH & family planning are you aware of?
2. Are any of these policies, laws, or frameworks PWD-specific? If so, how? If not how?
3. Have you been able to access all SRH & family planning services being provided in your community?
4. What are your family planning needs?
5. Out of the family planning needs you have mentioned above, which family planning service do you need the most?
6. Do you have or do you receive any information on sex education?
7. Which family planning services can you easily access?
8. Why do you think it is easy to access the family planning that you have mentioned above?
9. What has been your positive and negative experience with these services?

10. What do you think are the barriers and opportunities to access family planning services for PWDS?
11. Do you think the types of disability determine barriers and opportunities?
12. can you explain how you think the types of disabilities create barriers to accessing family planning?
13. In your case, where do you get the service of family planning?
14. What is the reaction to your quest for family planning?
15. How do you access family planning in the area of your choice?
16. How often do you access the family planning you mentioned above?
17. Do you know any other PWDS who fail to access family planning the way you do?
18. Why do you think the other disabilities fail to access family planning services?
19. Do you think that social identity or status (i.e., class, area of living, ethnicity, religion, and age) affects the access to avail the ser-vice or the nature of the benefits from the service?

Non-Beneficiary PWD

Gender: _____
Age range: 18-30
Marital status: _____
Ethnicity: _____
Religion: _____
Highest educational level: _____
Occupation: _____
Category of disability: _____
Possession of disability card: Yes. _____ No. _____

1. What national policy, law or framework on family planning are you aware of?
2. Are any of these policies, laws, or frameworks PWD-specific? If so, how? If not how?
3. Are you aware of family planning services that exist in your community?
4. Why have you not been able to access any of the family planning services that exist in your community?
5. What are your family planning needs? ((here we can probe for access to sex education, contraceptives, and informed decision-making about family expansion or we can ask direct questions)
6. What do you think are the barriers and opportunities to access family planning services for PWDS?
7. Do you think the types of disability determine barriers and opportunities to accessing family planning services?
8. How do you think the types of disability influence access to family planning services?
9. Do you think that social identity or status (i.e., class, area of living, ethnicity, religion, and age) affects the access to avail of the service or the nature of the benefits from the service?