Policy Brief on the Sexual and Reproductive Health Rights of Women and Girls with Disabilities in Kenya



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Acronyms

MARC	**Management Abortion Related Consequences**
NGOs	**Non-Governmental Organizations**
CRPD	**Convention on the Rights of Persons with Disabilities**
SRHR	**Sexual and Reproductive Health Rights**
SRH	**Sexual and Reproductive Health**

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1. Executive Summary

This policy brief aims to highlight the challenges and gaps in the sexual and reproductive health rights (SRHR) of women with disabilities in Kenya, and to provide recommendations for addressing them. Women with disabilities constitute about 2.5% of the total population of women in Kenya, according to the 2019 census. They face multiple forms of discrimination and barriers to accessing quality SRHR services, information, and education. They are often excluded from decision-making processes, subjected to stigma and violence, and denied their autonomy and dignity. These violations have negative impacts on their health, well-being, and empowerment. This Policy Brief identifies challenges and recommends solutions drawing on evidence from existing literature, and views gathered from focus group discussions and questionnaire responses from key stakeholders including women and girls with disabilities, organizations of persons with disabilities, and officials from relevant government departments. It focuses upon key areas comprising access to services including family planning, maternity care, infertility prevention and treatment, management of abortion related consequences, HIV prevention, and community-based services. It also looks upon access to education and information on SRHR, Gender based violence, participation and representation of women and girls with disabilities in decision making bodies, as well as challenges in existing policy frameworks.

2. Background

Kenya, a country in East Africa, is characterized by its diverse population and complex socio-economic landscape. According to the 2019 Kenya Population and Housing Census, the total enumerated population in Kenya was approximately 47.6 million. Of this, 24,014,716 (50.5%) were females whereas 23,548,056 (49.5%) were males indicating that the country has more females than males. Furthermore, while the overall disability prevalence rate according to the Kenya 2019 census, is 2.2% (0.9 million people), 1.9% of the total population of men have a disability compared with 2.5% of the total population of women indicating that women with disability have higher prevalence than men. Moreover, more people with disabilities (2.6%/0.7 million) live in rural areas than urban areas (1.4% (0.2 million). The 2019 census of Kenya reported a disability prevalence rate of 2.2%, much lower than the global estimate of 15%. This could have many reasons, such as: possibility of people with disabilities not wanting to admit their difficulties in the census, because of the discrimination and low self-esteem facing them; also, poor translation of the census questions on disability into local languages which may have confused respondents; omission of children under 5 years old who may have different or fewer difficulties than older people, and Kenya having a greater young population, while disability is more common in older people who may have more health issues, injuries, or impairments.

3. Legal and Policy Framework

3.1 At international level

The Convention on the Rights of Persons with Disabilities (CRPD) recognizes persons with disabilities to include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal

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basis with others[1]. It recognises the right of women with disabilities to sexual and reproductive health including by imposing a duty on State Parties to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes[2] Other major international frameworks also emphasize the rights of women and girls with disabilities to SRH as part of broader provisions for all women, as well as all children and adolescents. These include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which requires States to ensure that women and girls with disabilities have access to reproductive health care and are protected from coercive pressures[3]. The Convention on the Rights of the Child (CRC) further protects the rights of children and adolescents with disabilities to ensure that they have effective access to health-care services (article 23).

3.2 At Regional Level

Article 17 of the Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa (Africa Disability Protocol) guarantees every person with disability the right to the highest attainable standard of health. The protocol further imposes a duty upon State parties to ensure that women and girls with disabilities have equal and full enjoyment of their rights including sexual and reproductive health rights as well as the right to retain and control their fertility and to not get sterilized without their consent.

3.3 At National Level

Article 43 of the Constitution of Kenya (2010) states that every Kenyan has a right to quality and affordable health care, including reproductive health. It further states that no Kenyan can be denied access to emergency health services when in need. The implication of this Article is that barriers to health care services of whatever kind will not hinder the right to access, hence the Government is duty bound to remove such barriers so that health rights are met.

Research indicates that women and girls with disabilities experience multiple layers of discrimination due to both their gender and disability. This often results in what is known as "double discrimination." Unfortunately, their voices are frequently excluded from important national, regional, and international discussions, laws, and policies, making their issues inadequately comprehended and addressed. To address these issues, several legal and policy initiatives have been taken to promote sexual and reproductive health rights of women and girls with disabilities in Kenya. For instance, the move to have a law which guarantees women with disabilities with rights including to control their sexuality and reproductive health, protection from sexual and gender-based violence, provision of habilitation, rehabilitation and psychosocial support against sexual and gender based violence; access to sexual and reproductive health services; retainment and control their fertility; as well as protection against all forms of sexual abuse in all settings at all places[4]. Also, steps to place legal obligations upon

[1] CRPD, Article 1, https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

[2] UNCRPD, Article 25(a).

[3] CEDAW, General recommendations no. 21 on the Elimination of Discrimination against Women (1994), https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#top at para. 22

[4] The Reproductive Healthcare Bill, (2019), Kenya Gazette Supplement No. 186 (Senate Bills No. 23), http://www.parliament.go.ke/sites/default/files/2020-02/Reproductive%20Healthcare%20Bill%2C%202019.pdf

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County governments to facilitate access to reproductive health services by persons with disabilities in respective counties including by providing physical access to health facilities; putting in place mechanisms for access to information and communication materials on reproductive health in a form that is accessible by all persons with disabilities; providing continuing education and inclusion of rights of persons with disabilities among health care providers; and undertaking activities to raise awareness and address misconceptions among the general public on the stigma and their lack of knowledge on the reproductive health needs and rights of persons with disabilities[5].

At Policy level, the Kenya National Reproductive Health Policy (2022 – 2032) recognizes that persons with Disability have special reproductive health needs, hence expresses the intention to prioritize integration of reproductive health services that are responsive to the needs of persons with disabilities[6]. This includes by using health education materials in Braille and Sign language and other appropriate means of communication and enhancing health infrastructures[7]. The Policy has an impact level indicator to that effect namely, "Existence of specific policies and resources for disability mainstreaming in reproductive health service delivery points" with a proposed 30% 2030 achievement target[8]. Moreover, the Menstrual Hygiene Management Policy (2019-2030) also speaks of developing a menstrual hygiene management communication strategy which takes persons with disabilities into consideration; and addressing the special needs, interests, and priorities of persons with disabilities in the planning of, investment in, and the promotion of Menstrual Hygiene Services and facilities[9]. Additionally, the Kenya National Family Planning Guidelines for Service Providers also acknowledge that persons with disabilities face barriers to accessing family planning information and services[10]. The guidelines impose a duty on service providers to ensure that there is equitable access to services for all. They mention persons with disabilities among clients with special needs requiring extra attention from health care providers[11] **.**

4. Methodology

In this policy brief, our research methodology encompassed a mixed-methods approach, integrating both quantitative and qualitative data collection techniques. We engaged 15 women and girls with a range of disabilities, including physical, visual, hearing, and psychosocial impairments, selected from This Ability's "Mama Siri" and "Digital Dadas" programs, alongside 17 key stakeholders from various relevant sectors such as government bodies, health departments, and disability organizations across

[5] Ibid.

[6] Ministry of Health, The National Reproductive Health Policy 2022 - 2032, Government of Kenya, July 2022 http://guidelines.health.go.ke:8000/media/The_National_Reproductive_Health_Policy_2022_-_2032.pdf at p.19.

[7] Ibid, at p.25 and 39.

[8] Ibid, at p. 50.

[9] Menstrual Hygiene Management Policy 2019-2030 http://guidelines.health.go.ke:8000/media/Menstrual_Hygiene_Management_Policy_2019-2030-_May2020.pdf at p. 4 and 12.

[10] Ministry of Health, Division of Family Health, Family Planning Program. National Family Planning Guidelines for Service Providers 6th Edition. Nairobi, Kenya: RMHSU, Oct 2018. Print. https://tciurbanhealth.org/wp-content/uploads/2019/04/Kenya-National-Family-Planning-Guidelines-6th-Edition-for-Print.pdf at p.13

[11] Ibid, at p.37.

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14 Kenyan counties including Mombasa, Kilifi, Kakamega, Kwale, Kisumu, Nairobi, Kajiado, Wajir, Isiolo, Mandera, Narok, Marsabit, Embu, and Uasin Gishu. The methodology involved conducting surveys to gather quantitative data on the experiences and perceptions regarding SRH services, complemented by in-depth interviews for qualitative insights into the challenges and potential solutions. Ethical considerations, such as informed consent and confidentiality, were rigorously upheld. This research was further enriched by a comprehensive review of existing literature in the fields of disability rights and SRH services, ensuring a well-rounded analysis that draws from both primary data and existing literature.

5. Problem Statement

Despite increased visibility of sexual and reproductive health and rights on global, regional, and national political agendas, meaningful implementation remains lacking when it comes to including women with disabilities[12]. The reality is that these women face numerous challenges related to their sexual and reproductive health. Society often overlooks their sexuality, reproductive concerns, aspirations, and fundamental human rights. Women with disabilities are sometimes infantilized and wrongly perceived as asexual[13]. They encounter obstacles such as lack of consent in sexual and reproductive health decision-making, negative attitudes from medical professionals, violence, and limited access to services due to physical inaccessibility. Additionally, coercive, and involuntary sterilization practices are still prevalent[14].

Moreover, information and education related to sexual and reproductive health, including topics such as menstrual health, contraception, pregnancy, safe abortion, and other relevant issues, are often inadequately presented in formats that are inaccessible to women and girls with diverse disabilities. Consequently, women with disabilities have not enjoyed equal access to high-quality sexual and reproductive healthcare. The lack of visibility regarding their sexuality places them in vulnerable situations, increasing their risk of experiencing forced sterilization, sexual violence, unplanned pregnancies, and other challenges. While there has been advancement towards acknowledging and addressing the SRH needs of women with disabilities, the gaps and challenges that continue to persist show that the optimism embodied in the policy and legal initiatives still need to be translated into realism.

5.1 The State of Access to Services

5.1.1 Contraceptives and Family Planning Services

In accessing family planning services, respondents mentioned challenges including the negative attitude of some healthcare providers, who do not recognize or respect their disabilities, especially invisible disabilities like Psychosocial disabilities. Some of these providers treat them with disdain, stigma, or discrimination, and deprive them of quality care or information. Some also mentioned infringement of freedom of choice where women with disabilities are pressured to adopt certain

[12] Information from This Ability Trust.

[13] Ibid.

[14] Ibid. See also Kenyan Network Advocating for the Rights of Women and Girls with Disabilities; NGO Submission on Kenya to the Committee on the Convention on Elimination of Discrimination Against Women (CEDAW); 68th Session (2017). (Unpublished)

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family planning methods, such as sterilization or long-acting contraceptives, without considering their preferences, needs, or consent.

Communication barriers especially for Deaf and Blind women were also identified. The women can hardly access Sign Language interpretation, or information materials in accessible formats like Braille print. This hampers their ability to communicate with healthcare providers, and to understand the benefits and risks of different family planning methods. Also, physical barriers like lack of elevators and accessible toilets especially for women with physical disabilities were also noted to hinder their access to facilities where family planning services are offered. Moreover, constrained informed consent was also noted by some women with disabilities including due to lacking legal capacity to make their own decisions as well as dominance of men in family planning decisions especially in patriarchal societies. This exposes them to pressure from their families, guardians, or partners to adopt certain family planning methods, violates their autonomy and dignity, and exposes them to potential abuse or exploitation. Similarly, for women with Sickle cell, genotype testing was noted to be important when they want to plan their families. However, this testing is only available in level 5 hospitals in the country making it difficult for them to know their genetic risk to make informed decisions[15].

5.1.2 Maternity Care Services

For antenatal, safe delivery and post-natal care, multiple gaps were identified. These include discriminatory behavior by some health workers during labor or clinic sessions. For example, some respondents attested to health workers being scared to touch them, while others were spoken to in a derogatory manner referencing their disabilities. Furthermore, poor understanding and consideration of differences in challenges stemming from different types of disabilities was also noted among health workers. For example, for women with Spina bifida or brittle bones, it is not well understood by some health workers that such women require special attention for instance where epidurals and total bed rest are required. One Short Stature woman shared her experience that even though during her prenatal visits the doctor had instructed that due to the nature of her disability it wasn't necessary to get a cervical examination. However, when she went to the hospital, nurses ignored her and proceeded to conduct a cervical exam causing her discomfort. Also, for Deaf women, they rely on Sign-Language, lip reading or writing down their requests to communicate with healthcare providers. However, most health care providers do not understand this thus creating a communication barrier for them.

Unaccommodating infrastructures such as maternity beds that are not adjustable or accessible in health facilities especially by women with physical impairments were also noted. Respondents also mentioned poor provision of education and counseling services for Women with disabilities, especially after child delivery. That Women with disabilities receive inadequate information or support on how to care for themselves and their babies. For instance, information on breastfeeding, nutrition, family planning, and mental health. Also, lack of autonomy in decision making for Women with disabilities, especially those with severe disabilities.

[15] This Ability Trust

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5.1.3 Infertility Prevention and Treatment

Infertility prevention and treatment services are essential for the reproductive health and well-being of Women with disabilities but were noted to be inaccessible for various reasons. The reasons included the services being too expensive hence beyond the reach of most Women with disabilities who mostly have low income. Second, these services are mostly available in urban areas, leaving out rural areas where most of the population of persons with disabilities lives. This means that women and girls with disabilities must travel long distances, face transportation challenges, and incur additional costs to access these services. The lack of autonomy in decision making was also mentioned as a challenge in accessing these services.

5.1.4 Management of Abortion Related Consequences (MARC)

One of the challenges identified in accessing services on management of abortion related consequences (MARC) is the lack of information on what steps to take post-abortion, such as where to seek medical care, how to prevent infections, and what legal rights they have. Another obstacle is the scarcity and inadequacy of facilities that provide MARC services, especially in rural areas. Women with disabilities often must travel long distances, face discrimination and stigma, and encounter physical and financial barriers to access quality care. Moreover, some Women with disabilities end up having to choose abortion, when pregnant due to rape, as they find themselves not ready for childcare. This is a violation of their reproductive rights and autonomy and exposes them to further risks of unsafe abortion and its consequences. Therefore, there is an urgent need to address the gaps facing Women with disabilities in Kenya in accessing services of management of abortion related consequences, and to ensure that they receive comprehensive, respectful, and rights-based care.

5.1.5 HIV Prevention Services

Poor access to HIV prevention services was also noted by the respondent women with disabilities. Some of the factors contributing to this include difficulty in attending Antiretroviral (ARV) appointments, especially when they do not have adequate support from their families or caregivers. This can compromise their adherence to treatment and increase the risk of developing drug resistance or transmitting the virus to others. Also, refusal by their partners to use condoms and coercion into unwanted sex which exposes them to repeated infections. Respondents also noted the existence of limited access to information and education on HIV prevention measures, such as how to use female condoms, Pre-exposure Prophylaxis (PrEP), or Post-exposure Prophylaxis (PEP). This is partly due to the stigma and discrimination they face in health facilities, as well as the lack of disability-friendly materials and services. Blind women for example who often face inaccessible information, end up having to use assistance. This exposes their private information like medical diagnoses and medication to third parties, thus violating their right to confidentiality and independence, showing a lack of inclusive and respectful healthcare practices.

5.1.6 Community Based Services

Another challenge that was noted was limited access to community-based services that address sexual and reproductive health rights of women and girls with disabilities in Kenya. This is partly because most of these services are concentrated in urban areas, leaving out the rural and remote populations. Moreover, the community health promoters who are supposed to provide these services are often unaware of the specific needs and preferences of different types of disabilities, especially those with

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psychosocial impairments. Additionally, although the electronic community health information system, a reporting tool for community health services captures information on disability, it does not disaggregate the disability data, thus excluding some groups from the data and analysis. These gaps undermine the quality and effectiveness of the community-based services regarding women and girls with disabilities to access sexual and reproductive health care.

5.2 Education and Information

Regarding access to education and information on sexual and reproductive health rights, Women with disabilities in Kenya, multiple barriers were identified including physical, social, economic, and cultural factors that limit their participation and inclusion in society. Some of the barriers include social isolation and stigma, lack of accessible and inclusive educational facilities and materials such as sign language interpreters, braille print, and assistive devices for Women with disabilities who are often excluded from mainstream education and information services. Furthermore, the lack of awareness of their rights limits them from voicing their needs and concerns regarding sexual and reproductive health rights issues and to access relevant information and support.

Various SRH education interventions including by Community Health Volunteers (CHVs), social media, and local barazas were identified. However, majority respondents expressed the view that the SRH education available is inadequate to meet the needs of women and girls with disabilities as shown in *figure 1* below. Moreover, healthcare providers were also noted to be inadequately educated about the special needs of women with disabilities. For example, some health workers think that women with Spina Bifida only need to use folic acid once pregnant, even though these women should be using it frequently when trying to get pregnant. Healthcare providers also lack adequate readiness in terms of emergency preparedness for hospital services when attending to sickle cell patients during childbirth. Therefore, there is a need for more inclusive and accessible education and information programs that address the specific needs and rights of Women with disabilities**.**

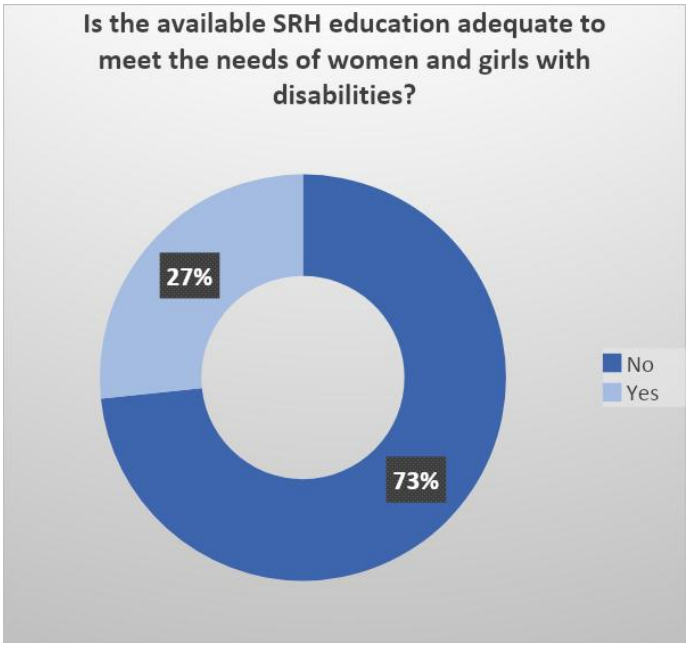


Figure 1

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5.3 Gender Based Violence

Regarding Gender-based violence (GBV), respondents identified several challenges including some Women with disabilities facing Female genital mutilation (FGM), rape and defilement, intimate partner violence, and neglect. It was also noted that women with Psychosocial disabilities like epilepsy experience poor sex drive due to side effects of their medications. This puts them in sexual violation by their partners who often do not respect their consent to sex. Moreover, poor self-esteem causes Women with disabilities to hide their GBV experiences especially where perpetrators are family members who may threaten or manipulate them.

Respondents identified the Penal Code and Sexual Offences Act (2006) as among laws providing for protection of women and girls with disabilities against Gender Based Violence. Response mechanisms including free medical care at the government hospitals, access to police gender desks, rescue centers and availability of toll-free lines to report GBV cases were also mentioned. However, most respondents as illustrated in *figure 2* below were of the view that the mechanisms are not effective enough. It was also noted that the justice system is often unaccommodating and sometimes discourages the Women with disabilities from taking legal action against perpetrators. This is because many Women with disabilities are unaware of their rights as well as processes in the justice system; they face barriers such as inaccessible facilities, lack of sign language interpreters, and prejudice from justice officials; and they face financial constraints and corruption hence unable to hire competent lawyers to defend their cases. Respondents also noted poor response from law enforcement where Women with disabilities report cases of rape. These challenges make it difficult for Women with disabilities to access justice and protection from gender-based violence.

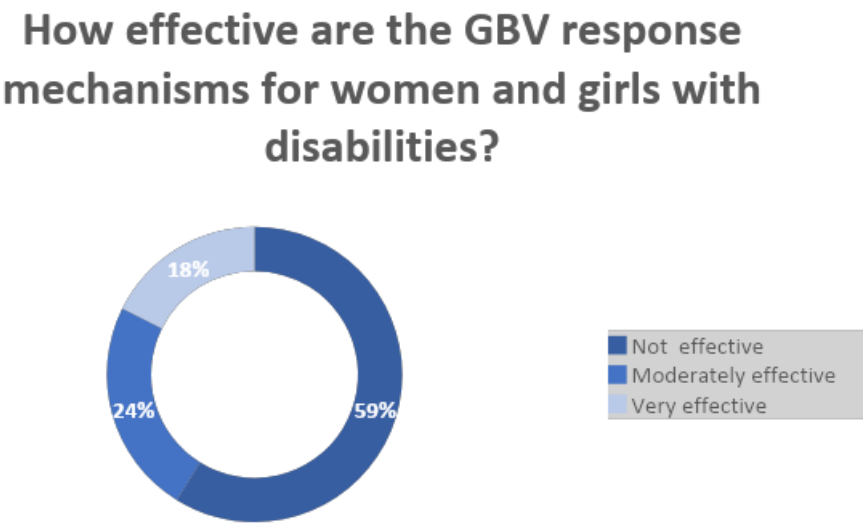


Figure 2

5.4 Participation and Representation

Representation in decision making bodies regarding sexual and reproductive health rights was another challenge identified by the respondents. It was noted that women with disabilities are seldom represented in these bodies, and when they are, they face multiple barriers and discrimination. Also, affirmative action measures, such as the parliamentary special seats, are not exclusively for women,

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and thus do not guarantee their inclusion. Moreover, women with disabilities in parliament hardly speak on disability related issues. This situation undermines the voice and agency of women and girls with disabilities and prevents them from advancing their rights and interests.

5.5 Existing Policy Frameworks

The lack of a comprehensive and inclusive legal and policy framework that recognizes and addresses specific needs of women and girls with disabilities in access to sexual and reproductive health rights was also noted to be a challenge. Although Kenya has ratified the Convention on the Rights of Persons with Disabilities (CRPD), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) the Protocol to the African and Peoples' Rights on the Rights of Persons with Disabilities in Africa, which affirm the sexual and reproductive health rights of women and girls with disabilities, it has not fully domesticated these instruments in national laws and policies. It has been noted that sexual and reproductive health rights of women and girls with disabilities have been explicitly acknowledged by policy documents including the Kenya National Reproductive Health Policy (2022 – 2032), the Menstrual Hygiene Management Policy (2019-2030), and the Kenya National Family Planning Guidelines for Service Providers. However, in other important policies like the National Nursing and Midwifery Policy (2022-2032), explicit reference to disability specific issues is hardly made. This may be partially due inadequacy of comprehensive data on women and girls with disabilities particularly regarding access to sexual and reproductive health rights. A gap in the availability of disability prevalence data creates a huge risk of designing programs and solutions that do not comprehensively address their challenges and needs. Seeing that the laws and policies available provide limited protections for women and girls with disabilities regarding sexual and reproductive health rights, and that **SRH services for women with disabilities do not adequately meet their needs** as is reflected by a 73.33% majority view in figure 3 below, there is great need for a policy framework exclusively tailored for addressing this.

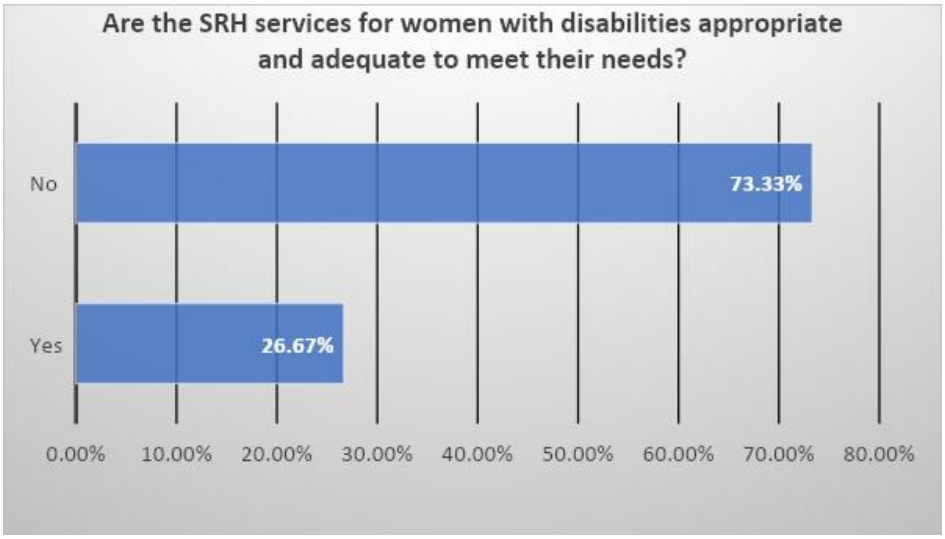


Figure 3

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6. Recommendations

To address these gaps, there is a need for a comprehensive and inclusive policy developed based on a holistic and human rights-based approach to sexual and reproductive health service provision for women and girls with disabilities in Kenya. This Policy should be based on the following recommendations:

6.1 The State of Access to Services

6.1.1 Contraception and Family Planning

1. Improve the attitude and skills of healthcare providers towards women and girls with disabilities, especially those with invisible disabilities. This can be done through training, awareness-raising, and supervision with special focus on rural areas to ensure that they provide respectful, quality, and inclusive care.
2. Promote the freedom of choice and autonomy of women and girls with disabilities over their family planning methods. This can be done by ensuring that they have access to a range of safe and effective methods, that they receive comprehensive information and counseling, and that they are able to give their free and informed consent.
3. Enhance the communication and accessibility of health care services for Women with disabilities especially Deaf and Blind persons. This can be done by providing communication aids including Sign Language interpreters and Braille print, using simple and clear language, and involving women and girls with disabilities in the design and delivery of the services.
4. Remove the physical barriers in hospital infrastructures that hinder the access of women and girls with disabilities to family planning services. This can be done by adopting universal design principles, providing assistive devices and equipment, and ensuring that the facilities are easy to reach and navigate.
5. Sensitize women and girls with disabilities and health workers on informed consent including on provision of adequate information and counseling, respecting their preferences and opinions, and supporting their decision-making capacity regarding family planning.
6. Set up more disability inclusive clinics in different parts of the country. These clinics should offer complete care for women with disabilities such as Folic acid supplements for Women with **Spina** bifida, counseling, and other services.
7. Allocate funds for genotype testing machines for persons with genetic conditions like Sickle Cell. These machines should be available in all healthcare facilities in the county. Genotype testing should be affordable or free, so that they can make informed choices about their reproductive health.
8. Engage men as allies and partners, educating them on the benefits of family planning, and addressing the gender norms and stereotypes that limit women's agency.
9. Enforce legal and human rights protections, raising awareness on the harms and consequences of harmful practices like forced sterilization of young girls with disability, and providing alternative support and services to their families.

6.1.2 Maternity Care

1. Sensitize and train health workers especially those in rural areas on the rights and needs of Women with disabilities, and how to provide respectful and inclusive maternity care for them.

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This can help reduce discrimination and mistreatment of Women with disabilities and improve their trust and satisfaction with maternity services.

2. Improve the accessibility and adaptability of infrastructures in health facilities, such as maternity beds, weighing scales, toilets, ramps, doors, etc. This can help Women with disabilities use the facilities more easily and safely and reduce the barriers they face in accessing maternity care.
3. Provide comprehensive and tailored education and counseling services for Women with disabilities, especially after child delivery. This can help Women with disabilities gain more knowledge and skills on how to care for themselves and their babies and address any issues or concerns they may have.
4. Enhance the understanding of disability etiquette and consideration of differences in challenges stemming from different types of disabilities among health workers including maternity health workers and ensuring that they have the necessary resources and equipment and accommodations to provide appropriate care for Women with disabilities.
5. Promote the autonomy and participation of Women with disabilities in decision making regarding their own maternity care and respecting their choices and preferences.

6.1.3 Infertility Prevention and Treatment

1. Subsidize the cost of infertility treatment for women with disabilities or provide them with health insurance that covers these services.
2. Expand the availability of infertility services in rural areas or provide mobile clinics that can reach remote locations.
3. Empower women and girls with disabilities to make informed decisions about their reproductive health, by providing them with information, education, and counseling.

6.1.4 Management of Abortion Related Consequences

1. Providing Women with disabilities with accurate and accessible information on post-abortion care, legal rights, and available services through various channels, such as radio, SMS, and peer educators.
2. Strengthening the capacity and quality of facilities that offer services on management of abortion related consequences, especially in rural areas, by ensuring adequate equipment, supplies, training, and referral systems.
3. Promoting the reproductive rights and autonomy of Women with disabilities, and preventing unwanted pregnancies due to rape, by providing them with comprehensive sexuality education, family planning, and psychosocial support.
4. Reducing the discrimination and stigma faced by Women with disabilities who seek services on management of abortion related consequences, by raising awareness and sensitizing health workers, community members, and policy makers on the specific needs and rights of Women with disabilities.

6.1.5 HIV Prevention Services

1. Increasing home-based care and mobile clinics that can reach Women with disabilities in remote areas and provide them with ARV drugs and counseling. This would reduce the barriers and costs of transportation and increase the chances of adherence and retention in care. It

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would also enable Women with disabilities to receive regular monitoring and support from health professionals and peers.

2. Subsidizing health care costs for all persons with disabilities including women and girls.
3. Increasing awareness and advocacy campaigns that promote the rights and dignity of Women with disabilities, as well as legal and psychosocial support for survivors of gender-based violence. This would empower Women with disabilities to assert their sexual and reproductive rights and negotiate safer sex practices with their partners. It would also help them to access justice and healing in case of abuse or violence.
4. Increasing training and sensitization of health workers on the specific needs and concerns of Women with disabilities, as well as the provision of accessible and inclusive information and communication technologies (ICTs) that can disseminate HIV prevention messages to Women with disabilities.

6.1.6 Community Based Services

1. Expanding the coverage of community-based services to reach more rural and remote areas, where women and girls with disabilities may face more barriers and stigma.
2. Training and sensitizing the community health promoters on the different types of disabilities and their specific sexual and reproductive health needs, preferences, and rights.
3. Developing and implementing a more inclusive and disaggregated reporting tool that captures the diversity of disabilities and their access to community-based services.
4. Engaging women and girls with disabilities in the design, implementation, and evaluation of community-based services, to ensure that they are responsive, participatory, and respectful of their rights.

6.2 Education and information

1. Developing and expanding virtual educational platforms like SKILLS[16] , which are designed with inclusivity and accessibility at their core for accommodating the needs of women with various disabilities. For instance, by having key features such as text-to-speech, grey scale text, and text enlargement cater to those with visual and hearing impairments.
2. Promoting toll-free services like "Mama Siri"[17] which provide critical information to women and girls with disabilities. Such services offer guidance on gender-based violence, sexual and reproductive health services, legal rights, and mental health support. Accessible via call or text, they ensure vital resources are within reach for women and girls with disabilities.
3. Improving the accessibility and inclusivity of educational infrastructure and resources, by providing ramps, Sign language interpreters, Braille books, assistive devices[18], and other accommodations.

[16] This Ability Trust, Programs, https://www.this-ability.org/skills-page/

[17] This Ability Trust, https://www.this-ability.org/mama-siri/

[18] Assistive devices for persons with disabilities are diverse and cater to various needs. For mobility impairments, there are wheelchairs, walkers, canes, and prosthetic limbs. Visual impairments are aided by Braille readers, screen readers, spectacles, magnifiers, and white canes. Hearing impairments can be assisted with hearing aids, cochlear implants, and assistive listening devices. Speech generating devices and voice amplifiers are available for speech impairments. Cognitive impairments benefit from memory aids and adaptive software, while those with fine motor skill impairments can use adaptive keyboards and mice, as well as writing aids. Lastly, daily living aids like adaptive eating utensils and dressing aids assist in routine tasks. These devices significantly enhance functionality and independence for persons with disabilities.

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4. Incorporate Braille on medicine or pills packaging, documents, and labels providing vital instructions that empower patients to manage their medications autonomously and make informed healthcare decisions.
5. Designating a specific focal person in all hospitals to facilitate and ensure that persons with disabilities including women and girls access inclusive health services.
6. Sensitizing and training health workers, educators, peers, and community members on the rights and needs of women and girls with disabilities especially those with more rarely understood conditions like Spinal- bifida, Sickle cell, and Cerebral palsy and promoting positive attitudes and behaviors towards them.
7. Integrate the rights of women with disabilities into the healthcare providers training curriculum. Their curriculum should encompass various aspects, including learning Sign Language, rights of women with disabilities when accessing healthcare and understanding the unique needs of disabilities. This training should encompass both medical and interpersonal competencies to ensure a comprehensive approach to patient care.
8. Providing financial assistance and social protection to women and girls with disabilities, to enable them to afford school fees, uniforms, transportation, health care, and other necessities.
9. Raising awareness and empowerment of women and girls with disabilities on their sexual and reproductive health rights, and services available to that effect by providing them with accurate information, counseling, education, and advocacy.
10. Consult women and girls with disabilities especially those with Psychosocial disabilities when planning for sensitization of health workers, so that their specific issues are addressed.

6.3. Gender Based Violence

1. Developing strong referral mechanisms for responding to GBV incidents involving women and girls with disabilities in Kenya. This can include toll-free services like "Mama Siri"[19] which have a centralized database for case management, partnering with local healthcare providers, law enforcement, and legal services.
2. Providing psycho-social support for survivors of violence, such as counseling and therapy. This can help them cope with the trauma, improve their physical and mental health, enhance their mood and confidence, and strengthen their relationships with others.
3. Implementing economic and social empowerment programs for women and girls with disabilities, such as cash transfers, vocational training, and microfinance. This can help them gain financial independence, reduce their dependence on abusive partners or relatives, increase their access to education and health services, and improve their social status and participation.
4. Working with couples and families to improve communication and relationship skills, and to reduce conflict and violence. This can help them resolve disputes peacefully, respect each other's rights and needs, promote mutual support, and trust, and prevent further abuse.
5. Mobilizing communities to change unequal gender norms that condone or justify violence against women and girls with disabilities. This can help them challenge stereotypes and stigma, raise awareness and education on human rights and gender equality, foster positive

[19] This Ability Trust, Mama Siri, https://www.this-ability.org/mama-siri/

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attitudes and behaviors towards women and girls with disabilities, and create a supportive environment for survivors.

6. Strengthening the laws and policies that protect women and girls with disabilities from violence, such as the Sexual Offenses Act, and ensuring their enforcement and accountability. This can help them access justice and legal aid, report cases of violence without fear or shame, receive protection orders and compensation, and hold perpetrators accountable.

6.4 Participation and representation

1. Increasing the quota and reservation of seats for women with disabilities in decision making bodies, such as the parliament, county assemblies, public service commissions, and constitutional commissions. This would ensure that women with disabilities have a fair representation and a chance to influence the policies and laws that affect their lives.
2. Providing training and mentorship for women with disabilities in parliament and other leadership positions, such as civil society organizations, media, academia, and private sector. This would enhance their skills and confidence to speak on disability-related issues, as well as to network and collaborate with other stakeholders.
3. Creating platforms and networks for women with disabilities to share their experiences and advocate for their rights, such as online forums, social media groups, newsletters, podcasts, radio shows, and events. This would amplify their voices and raise awareness of the challenges and opportunities they face, as well as to showcase their achievements and contributions to society.
4. Raising awareness among the public and the policymakers on the issues and needs of women and girls with disabilities, such as through campaigns, publications, documentaries, workshops, seminars, and dialogues. This would challenge the stereotypes and stigma that women with disabilities face, as well as to promote their inclusion and empowerment in all spheres of life.

6.5 Existing Frameworks and Stakeholders Responsibilities

1. Promoting research and ensuring collection of accurate data on Persons with Disabilities disaggregated by gender, age, type of disability at the county and national level. This can be done through utilization of technological tools like “Hesabika”[20] , a USSD (Unstructured Supplementary Service Data) platform using mobile technology.
2. Promoting research and ensuring collection of accurate data on Persons with Disabilities disaggregated by gender, age, type of disability at the county and national level.
3. Strengthening the monitoring and accountability mechanisms to ensure that the laws and policies are effectively implemented and enforced, and that any violations of the sexual and reproductive health rights of women and girls with disabilities are promptly reported and redressed.
4. Conducting regular training and capacity-building for duty-bearers and service providers on the sexual and reproductive health rights of women and girls with disabilities, including their specific needs, challenges, preferences, and rights.

[20] This Ability Trust, Hesabika, https://www.this-ability.org/hesabika/

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5. Enhancing the participation and empowerment of women and girls with disabilities in the design, implementation, evaluation, and advocacy of sexual and reproductive health rights programs and policies, ensuring that their voices are heard and respected.
6. Increasing the availability and accessibility of quality, affordable, and comprehensive sexual and reproductive health rights services for women and girls with disabilities, including information, education, counseling, prevention, treatment, care, and support.
7. Disseminate the policies by using disability friendly methods. Including audio, videos with subtitles, and braille format along with translating them into simple local languages.

7. Conclusion

In conclusion, this policy brief has identified numerous challenges which highlight the urgent need for a comprehensive and inclusive policy that addresses the sexual and reproductive health rights of women and girls with disabilities in Kenya. Such a policy should be based on human rights principles, evidence-based interventions, and meaningful participation of women and girls with disabilities and their representative organizations. It should also ensure the availability, accessibility, acceptability, and quality of sexual and reproductive health rights services, information, and education for women and girls with disabilities, as well as the prevention and response to gender-based violence. A dedicated policy on SRHR for women and girls with disabilities would not only improve their health outcomes, but also contribute to their empowerment, dignity, and social inclusion.

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Information from This Ability Trust

Survey data for the Policy Brief