

Addis Ababa
University
(Since 1950)



ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES LAW SCHOOL

Sexual and Reproductive Health Rights of Women with Disabilities; The case of Women with sensory and physical impairment in Addis Ababa.

By Hanna Mulugeta

June, 2019



Sexual and Reproductive Health Rights of Women with Disabilities in Ethiopia, The case of Women with sensory and physical impairment in Addis Ababa.

By Hanna Mulugeta

Prepared under the Supervision of Yonas Birmeta (PHD, Assistant Professor)

A thesis submitted to school of Law, Addis Ababa University, in Partial Fulfillment of, the requirements for the degree of Master of Law in Human Rights Law

**Addis Ababa University
School of Graduate Studies
School of Law**



Declaration

I, Hanna Mulugeta, hereby declare that this research paper is an original work and has not been presented in any other institution before. All referred materials are duly acknowledged.

Name: Hanna Mulugeta

Signature

The dissertation has been submitted for examination with my approval as university advisor

Name of Advisor: Yonas Birmeta, (Assistant Professor, PhD) Signature _____

Board of Examiners Signature

1. Name _____ Signature _____

2. Name _____ Signature _____

3. Name _____ Signature _____

Acknowledgments

First and foremost I am thankful to the Almighty God and praise his name for this research would not have been accomplished without his assistances.

I am most grateful to my supervisor, Dr Yonas Bimeta . My deepest gratitude goes to Dr. Mizane, who has encouraged me and facilitated the path to the finish line of this paper. Dr.Yonas and Mizane you have both very kind and thoughtful heart God bless you abundantly.

The father of my Children, Mola Melaku, your support and encouraging words are my strength, every one witnessed how you believed in me. There you have the fruit. Emuye I have no words for your unwavering backing from my pregnancy to the birth of my children, you are a second mom to Rediet and Yeabkal. My mom and brother thank you for putting a smile in my face when everything seems down. Beletu you are a great nanny to my kids. Miki and Mehretab , thank you for your kind and honest comments .My friends Meron, Semhal, Tigist and Terefwork you are a blessing in my life I could not treasure you with anything.

I have dedicated this paper to my late sister and father, who would have been the happiest in the whole world. I miss you both terribly!

List of Acronyms

CEDAW - Convention on the Elimination of Discrimination against women

CESCR- Convention on Economic, Social and Cultural Rights

CRPD-Convention on the Rights of Persons with Disabilities

CSA – Central Statistics Agency

CSO- Civil society Organization

DPO- Disabled People’s organization

ECCD- Ethiopian Center for

ENDA- Ethiopian National Deaf Association

ENWDA- Ethiopian National Women with Disabilities Association

FDRE- Federal Democratic Republic of Ethiopia

FGM- Female Genital Mutilation

GBV- Gender based Violence

HTP- Harmful Traditional Practice

ICCPR – International Convention on Civil and Political Right

ICF- International Classification of Functioning,

KII- Key Informant Interview

NAP- National Action Plan

NGO- Non Governmental organizations

PWD- People with Disability

PWDS- Person with Disabilities

RHR- Reproductive health Right

SRH-Sexual and Reproductive Health

UN- United Nation

UNFPA- United Nation Population Fund

WHO- World Health Organization

WWD- Women with Disability

WWPD-Women with physical disabilities

Table of Content

Acknowledgments.....	iv
List of Acronyms	ii
Table of Content	iii
Abstract.....	vi
Chapter One	1
1. General Introduction	1
1.1. Background.....	1
1.2. Statement of the Problem.....	3
1.3. Research Questions.....	4
1.4. Objective of the Research	4
1.5. Research Methodology	5
1.5.1. Research Paradigm.....	5
1.5.2. Research Design.....	5
1.5.3. Research Setting and Sampling.....	6
1.5.4. Sources of Data and Methods of Data Collection	6
1.5.5. Methods of Data Analysis and Interpretation	6
1.6. Ethical Considerations	7
1.7. Literature Review.....	7
1.7 Significance of the Research.....	8
1.8. Scope of the Research.....	9
1.9. Structure of the Thesis	9
Chapter Two.....	11
2. The International Human Right Regime on the Protection and Realization of Reproductive Health Rights of Women with Disabilities.....	11
2.1. Introduction.....	11
2.2. Definition of Disability.	12
2.3. Definition of Reproductive Health.....	13
2.4. Conceptualizing Reproductive Health Right: Models of Reproductive Health Rights.....	14
2.5. The International and Regional Legal basis of Reproductive Health Rights	15

2.5.1.	Reproductive Health in the context of ICPD	15
2.5.2.	The Protocol to the African Charter on the Rights of Women in Africa (the Maputo Protocol) 17	
2.5.3	The ICESCR, CEDAW and Other Related UN Body Instruments.....	19
2.6.	Normative Contents of the Right to Reproductive Health	23
2.7.	State’s Obligation to the Reproductive Health Rights under the International and Regional Frameworks.....	26
Conclusion		35
Chapter Three.....		37
3.	The Ethiopian Legal and Institutional Framework	37
3.1.	The Legal and Policy Framework on the Reproductive Health Rights of Women with Disabilities	37
3.1.1.	<i>Constitution of the Federal Democratic Republic of Ethiopia</i>	37
3.1.2	<i>The 2005 Criminal Code and the Revised Family Code</i>	41
3.2.	Institutional frameworks on the Right to Reproductive Health Right of WWD.....	42
3.2.1.	<i>Governmental-Stakeholders</i>	42
3.2.2.	<i>National Statutory bodies</i>	44
3.2.2.1.	<i>The National Human Rights Commission</i>	44
3.2.2.2.	<i>The Ethiopian Institution of the Ombudsman (EIO)</i>	45
3.2.3.	<i>Non-state Actors</i>	46
3.3.	Realizing Reproductive Health Rights of WWD	46
3.3.1.	<i>Barriers to reproductive health rights in Ethiopia, a case study in Addis Ababa</i>	47
3.3.1.1.	<i>Barriers on Reproductive Healthcare Delivery</i>	48
3.3.1.2.	<i>Justifiability and Legal Protection of Reproductive Health Rights</i>	51
3.3.2.	<i>Ensuring Access to Justice for WWD and Overcoming Barriers</i>	53
Conclusion		55
Chapter Four		58
4.	Conclusion and recommendation.....	58
4.1	Conclusion	58
4.2	Recommendation	61
4.2.1	Recommendation on the legal and Policy framework	61
4.4.2	Recommendation on the institutional framework	62

4.2.3 Recommendation on DPO and CSO, concerned stakeholders.....	63
BIBLOGRAHY	64

Abstract

The international paradigm is moving towards a more robust recognition of both the human rights of persons with disabilities and the rights of women. Article 6 of the UNCRPD recognizes the full and equal enjoyment by women and girls with disabilities of all human rights and fundamental freedoms. The recognition of reproductive health right as a human right under international human rights law has been sporadic, piecemeal, and indirect, yet reproductive health rights are fundamental and autonomous human rights to women. The intersection comprising the right of women with disabilities and their reproductive entitlement, right and freedom has not been given due attention in the world especially in developing countries and Ethiopia is not an exception.

The double vulnerability of women with disabilities exposes them to a multifaceted violation and mistreatment to the enjoyment of their rights inter alia. Therefore in order to ensure the respect, protection and promotion of these rights, it is essential to identify barriers that impede their realization and implementation. SRH services, information and education are inaccessible to women with disabilities for a plethora of normative, physical and societal reasons.

The paper tries to analyse the legal and institutional frame work pertaining to SRHR. It argues that the nonexistence, inadequacy and incompatible justice system and inaccessible reproductive healthcare delivery exacerbate the violation and infringement of these rights. The paper tries to unveil that assuring reproductive health and right to be accessible will circumvent barriers that transcend in practice the rhetoric of the rights secured for women with disabilities.

Chapter One

1. General Introduction

1.1. Background

Studies have indicated that maternal mortality, gender-based violence, lack of access to appropriate health care and an absence of family planning services drive violations of reproductive rights across the world.¹ Noticeably, women's rights are more violated than of male in relation to violation of reproductive health rights. This is to a large extent related to women's lower place in societies.

More worsening state of affairs of the problem is due to the fact that access to health is directly related with economic wellbeing. Most of the socio-economic rights realization is progressively, contingent up on the available resources. Studies have indicated that women have limited access to health. Access to health is directly related with economic wellbeing.² This can be extended to the continental level to reach a conclusion that Africa has the lowest rates of access to health.³

The problems related to sexual and reproductive health rights are aggravated by unfair laws and institutional set up. One big problem in this regard is the lack of data on the needs for and access to these health services by women with disabilities and even the number of women with disabilities.⁴

In resembling to any persons without disabilities, persons with disabilities have sexual and reproductive needs and are entitled to have their reproductive rights respected. The greatest hurdles to women with disabilities to exercise their reproductive rights stem from the ignorance and attitudes of societies and individuals, including health-care providers, rather than from the actual disabilities. The United Nations Convention on the Rights of Persons with Disabilities

¹Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions, UNFPA, 2012 pp 12.

²Richard Hofrichter, 'Tackling Health Inequities: A Framework for Public Health Practice', in Richard Hofrichter and Rajiv Bhatia (eds.), Tackling Health Inequities through Public Health Practice: Theory to Action (2nd ed, OUP 2010) pp4.

³ For the relationship between societal norms and respective for the sexual and reproductive health rights, see Renu Addlakha, Janet Price & Shirin Heidari (2017) Disability and sexuality: claiming sexual and reproductive rights, Reproductive Health Matters, 25:50, pp4-9.

⁴Kira Lee et al, Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines; BMC Women's Health (2015) 15:87; pp2. In Ethiopia, problem of data is critical (Committee on the Rights of Persons with Disabilities: Concluding observations on the initial report of Ethiopia, November 4, 2016).

(CRPD) has specific provisions that recognize the reproductive rights of persons with disabilities (Art. 23); the right of people with disabilities to access SRH information and services (Art. 25); and the specific need for empowerment of women with disability (Art. 6). In order for these rights to be achieved, women with disability need to be provided with age appropriate, accessible information on SRH, and to have recognition of their rights to have a sexual relationship, marry, establish a family, enjoy reproductive health, and physical integrity.

Despite major improvements in the health sector in Ethiopia, access to sexual and reproductive health services are still limited. For example, only 29% of women could access contraceptives.⁵

Ethiopia has ratified international and continental human rights instruments including the Convention on the Rights of People with Disability (CRPD). This convention has brought a major shift in the approach we understand disability and people with disabilities. This enabled the change from the medical approach that sees people with disabilities as people to care for to a social approach/model which locates disability in the social environment rather than on the body of the person.

The Ethiopian Constitution has provisions in support of promoting rights of women with disability by, among others, stating the obligation of the state to provide rehabilitation and assistance to the physically and mentally disabled.⁶

However, women with disabilities face a number of economic, social and attitude related problems. They have limited opportunity for education, health, training, employment, and accessibility. Their potential to lead normal lives is constrained by an absence of friendly physical environments, stigma and discriminative views. This is aggravated by the fact that many issues of disability, especially mental disability are addressed in informal (non-state) forums such as monasteries and homes.

⁵See Central Statistical Agency and ICF International, Ethiopia Demographic and Health Survey, (2012 Central Statistical Agency and ICF International) pp95.

⁶Art 41(5) of the FDRE Constitution reads, *'The State shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardian.'*

1.2. Statement of the Problem

If respect for sexual and reproductive health rights is limited for women, it must be worse for women with disabilities.⁷ There is ample evidence showing lack of information about and access to these health services.⁸ Their double vulnerability means their rights are majorly curtailed. Often there is an assumption that women with disabilities are not sexually active and therefore have no need for sexual and reproductive health services. Hence, women with disabilities are more often denied information about sexual and reproductive health.

Despite no single document exist devoted on it, reproductive health rights of women embrace certain human rights that are already recognized in national and international laws and international human rights documents and other documents of consensus. Ethiopia has adopted multiple human rights instruments which inculcate the derivative reproductive health rights including the ICCPR (Articles 6 and 10- right to life, security of person, and body integrity), ICESCR (Article 12- right to health), ICRPD (Article 25- highest attainable standard of health without discrimination on the basis of disability including reproductive health), CEDAW (Articles 12 and 16- freedom of discrimination of women from health care services including reproductive health) and CRC (Article 24- reproductive rights of children with disabilities).

Furthermore, Ethiopia has signed and ratified Maputo protocol, the protocol to the African Charter on Human and People's Rights on African Women.⁹ FDRE Constitution also deals with rights of women under its Article 36 and rights of person with disability under Article 41(5) including their rights to reproductive health.

Reproductive health rights is derivative rights embodied into numerous fundamental human rights, interdependent to other human rights and but with no single human rights instrument explicitly devoted on it. Hence, the scope of rights protected in relation to women reproductive health rights in Ethiopia in general and of the case of the women with physical disabilities in particular is not clear. Apart from its normative frameworks and national legislations that deal with women rights, health and rights of person with disability, triangulating the legislative,

⁷ On top of the historical legacy of the women being discriminated and marginalized from all matters concerning them, physical, psychological and mental disabilities multiplicities the vulnerability of women for their human rights violation including the reproductive health.

⁸Kira Lee et al, supra note 4, pp2.

⁹Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa Ratification Proclamation No. 1082/2018.

administrative and judicial implementation of the realization of the reproductive health rights of women with disabilities is concerns of instant worry to date in Ethiopia.

Though researches have been conducted on the reproductive and sexual rights of women in Ethiopia, this thesis will go one step further and address peculiarities related to one group of women, i.e., women with sensory and physical disabilities, related with reproductive health rights.

Hence, this thesis tries to analyze the legal and institutional framework and to some extent the practice of sexual and reproductive health rights of women with disabilities in Addis Ababa. It will also attempt to discover the compatibility of the national normative framework with international laws and obligations. In order to do this, it will attempt to define the international legal framework, national laws and institutional set up regarding sexual and reproductive health rights.

Moreover, it will deal with a situational analysis of access to reproductive health rights and services of sensory and physically impaired women in Addis Ababa.

1.3. Research Questions

To address the statement of the problem explained above, this thesis will respond to the following research questions:

1. What are the international legal framework related to sexual and reproductive health rights of women with physical disabilities in general and their right to family planning and information to reproductive health right education in particular?
2. What are the legal and institutional frameworks in Ethiopia regarding sexual and reproductive health rights of women with disabilities?
3. What are the constraints, at normative and institutional level, preventing women from accessing sexual and reproductive health services in Ethiopia?

1.4. Objective of the Research

This study has both general and specific objectives. The general objective of this study is to investigate the legal and institutional frame works in protection of reproductive health rights WWD in Ethiopia. The specific objectives of the study are:

1. To explore the international and regional Reproductive health right instruments dealing with WWDs in general and specifically their right to family planning and information
2. To analyses the national reproductive health legal instruments and institutional setups with respect to WWDs
3. To investigate the major challenges that concerned stakeholders at the governments and non -governmental bodies are facing in the implementation of RH rights of WWD?
4. To conduct situational analysis of access to reproductive Health rights and services of sensory and physically impaired women with particular focus on Addis Ababa.

1.5. Research Methodology

1.5.1. Research Paradigm

In exploring sexual and reproductive health rights of women with disabilities in Ethiopia, the legal and institutional frameworks, the challenges and limitations the researcher will follow interpretive paradigm. Besides asking, listening, recording and examining what the research participants say about the research problem and to have the researcher more active participation in the research process, the researcher will also follow an interpretive philosophical view. This worldview focuses on the meanings attributed to events, places, behaviors and interactions, people, and artifacts as observed and interpreted by the researcher and the research participants.¹⁰

1.5.2. Research Design

In conducting this study the researcher will employ a qualitative research design. Qualitative research approach mainly focuses on understanding, describing and discovering the meaning individuals or groups ascribe to a social or human problem.¹¹ It particularly seeks to understand a given research problem, topic, people, events or institutions from the perspective of the informants in a particular setting.¹² In exploring, describing and explaining the sexual and reproductive rights of women with disability in Ethiopia this study will follow qualitative phenomenological approach. This research approach helps to explore, describe and explain the lived experiences of human beings within a particular context and at a particular time.¹³

¹⁰Neuman, W., Social Research Methods: Qualitative and Quantitative Approaches, 2014.

¹¹ Creswell, J. W., Research Design: Qualitative, Quantitative and Mixed Methods Approaches, 2014.

¹² Ibid.

¹³Willig, C., Introducing Qualitative Research in Psychology, 2008.

1.5.3. Research Setting and Sampling

The participants of this study are going to be women with sensory and physical impairment, the Ministry of Labor and Social Affairs and the Ministry of Health, the Ministry of Women and Children Affairs, Non-Governmental Organizations, DPOs and Civil Societies which work in the area of women with disabilities.

Qualitative research, in general, is not concerned with whether or not the sample is representative of a large population; however, it is highly concerned with the quality and richness of the data.¹⁴ Thus, the research will follow a strategy in which particular settings or persons are purposively selected for the important information they may provide, which cannot be obtained from other sources.

1.5.4. Sources of Data and Methods of Data Collection

This study will use both primary and secondary data sources. Interview will be conducted based on pre-set interview guidelines to understand the major obstacles in providing access of sexual and reproductive health services to women with disabilities. The researcher will review documents international and national laws, regulations, directives, court cases, reports, plans, and others to access additional data in relation to the research topic and problem, specifically to explore the sexual and reproductive rights of women with disabilities.

1.5.5. Methods of Data Analysis and Interpretation

The data collected through interview, focus group discussion and observation will be analyzed through phenomenological data analysis scheme. As with all qualitative data, phenomenological data analysis involves such processes as coding, categorizing and making sense of the essential meanings of the phenomenon.¹⁵ To ensure the trustworthiness of the research process, the researcher will use data triangulation method. The data gathered through interviews, focus group discussion, and document analysis will be analyzed.¹⁶

¹⁴Babbie, E. *The Basics of Social Research*, Australia, 2015.

¹⁵Kleiman, S. *Phenomenology: To Wonder and Search for Meanings*. Nurse Researcher, 2004.

¹⁶Creswell, J. *Supra* at note 10, pp41.

1.6. Ethical Considerations

In conducting this research, the researcher will apply the usual academic ethical considerations. Specifically, this research will be conducted by respecting the privacy and anonymity of the participants, providing equal opportunity for all participants, securing the informed consent of the participants.

1.7. Literature Review

The purpose of this narrative is to lay out the various researches that have been done in the past in regard to this study. The review will also highlight pertinent and emerging issues with regard to addressing RHR predominantly family planning and the right to sexual and reproductive health information with visually and hearing impaired women.

A very limited research is conducted in the area of RHR of women. In fact, there is a dearth of literature in the area RHR of women with disabilities. Some of these researches conducted are concerning RH of women in the purview of the health constituents and services. However, to mention the few legal researches: Mekdes, F. in her research titled '*Implementation of Women's Right to Reproductive Health in Ethiopia; Policy and Health Care Perspective*' discussed the legal foundation of the right to reproductive health based on the states obligation to respect, protect and fulfill criteria. She was able to unveil major reproductive health problems in Ethiopia and listed that maternal mortality, harmful traditional practices, obstetric fistula and feminization of HIV/AIDS. Mekdes applied two indicators to monitor the implementation of reproductive health in Ethiopia, namely the long term human right situation versus the health indicators. She has concluded that even though Ethiopia has imported prominent international and regional legal instruments, a mere adoption and ratification is meaningless if norms do not have a favorable enforcement channel in the domestic arena. Institutional establishments like the Ethiopian Human Rights Commission and the Institute of Omdurman are futile as their independence, accessibility, capacity and the efficiency are the major obstacles in the implementation and that their role to RHR remains very limited. She has also added that the legal and health system operated as a separate entity and to fulfill the right to reproductive health courts and other law enforcement organs must be synchronized with the health system.

Kibebew P. has carried out a qualitative research titled ‘*The Right to Health of Mentally Ill Women at the Amanuel Hospital*’. By this research, the author attempted to address the quality of the health services for mentally ill women at the hospital, ranging from consent to treatment to the alternative treatments, freedom from sexual violence and the hygienic conditions at the hospital. He concluded that the conditions are not compatible with the human rights standards of the rights to get highest attainable standard of health, and the other human rights are threatened as there are recurrent sexual violence against women who are often admitted involuntarily.

The above researches have direct and indirect relevance for the reproductive rights of WWDs. However, it is clear that they are comprehensive on the reproductive health rights of WWDs in the larger context of the country, as the first one deals with the general implementation of RHR of women in general and its implementation with respect to a health care system and the second one emphasizes more on the health rights in general of a mentally ill women which is one form of disability. The other literatures on the Ethiopian situation are general situation analysis of the health rights of PWDS.

1.7 Significance of the Research

This research has the potential to add to jurisprudence by contributing to scholarship on the disability rights discourse in Ethiopia. In terms of practical significance, the research also has the potential to address gaps in the legal and policy framework with regards to reproductive health rights of women with disabilities, contributing to legal and policy reform in line with international best practices. Ethiopia is falling short of international standards by failing to align its laws with international standards. The non-recognition of WWDs as equal beings before the law is undesirable considering the voluntary commitments made by Ethiopia to be bound by international conventions that speak to the recognition of the reproductive health rights of women with Disabilities. It is hoped that Ethiopia will align its laws, policies and practices in line with international conventions and non-obligatory soft laws, declarations and consensus documents that provide reproductive health rights of women with disabilities.

1.8. Scope of the Research

No group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights, as women with disabilities.¹⁷ The CRPD Committee has clearly identified that discrimination against women and girls with disabilities in areas of sexual and reproductive rights, including gender-based violence, is in clear violation of multiple provisions of the CRPD.¹⁸ This paper examines the sexual and reproductive rights of women disabilities in the context of the international, regional and national laws. It deliberately focuses on women with physical disabilities in recognition that they are generally more likely to experience infringements of their sexual and reproductive rights given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Women with disabilities at their reproductive age 15- 49 are the main focus in the scope of this research.¹⁹ The paper excludes women with mental and intellectual disabilities, institutionalized women and WWD in a refugee or displaced settings. The research covers in detail of *women with physical and Sensory (hearing, speech, and vision disabilities)* to their reproductive health rights. It analyses some of the key sexual and reproductive rights violations experienced by women with disabilities in Ethiopia. Importantly, as opposed to ‘needs’, this paper speaks to the sexual and reproductive *rights* of women with disabilities – rights that for far too long have been violated, denied, ignored and trivialized by those in positions to make a difference.

1.9. Structure of the Thesis

This thesis is a final product with four chapters. The first chapter is an introduction. The second chapter looks into the international (including African) legal framework on sexual and reproductive health rights of women in general and women with disabilities in particular. Particular focus is provided to the analysis of the Convention on Rights of Persons with

¹⁷Manjoo, Rashida (2012) Report of the Special Rapporteur on violence against women, its causes and consequences; UN General Assembly; UN Doc. A/67/227

¹⁸The Committee on the Rights of Persons with Disabilities (CRPD) is the body of independent experts which monitors implementation of the Convention by the States Parties. See: <http://www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx>

¹⁹Reproductive health indicators, Guidelines for their generation , interpretation and analysis for global monitoring,WHO,https://apps.who.int/iris/bitstream/handle/10665/43185/924156315X_eng.pdf;jsessionid=62BA4CD63421AA370931A485928A640D?sequence=1 accessed on April 7, 2019.

Disabilities and the decisions of the CRPD Committee. The chapter in effect defines what sexual and reproductive health rights mean. Chapter three will address the Ethiopian legal and institutional framework. The chapter analyses the situation of women disability in relation to their rights to sexual and reproductive health in Ethiopia. This mainly focuses at the normative level and devotes on the practical challenges as found relevant for the normative framework. Finally, chapter four presents key research findings, conclusions, and recommendations as ways forward.

Chapter Two

2. The International Human Right Regime on the Protection and Realization of Reproductive Health Rights of Women with Disabilities

2.1. Introduction.

A robust concern about the neglect of PWDs began to be raised with the emergency of self-organization of PWD and thereby a growing tendency on the conception that disability as a human right issue were construed. The UN convention on the rights of persons with disabilities (CRPD)²⁰ was the first international convention that marked a paradigm shift in attitudes and approaches to PWDs looking at them not as objects but as subjects of rights.²¹ The CRPD recognizes the need for the promotion and protection of human rights of PWDs in civil, cultural, economic, political and social life, with the appropriate measures of implementation. Albeit the submission that the CRPD only introduces measures of implementation to accelerate the human rights, studies of WWDs requires a clear identification of individuals that deserve the protections and the extent to which these protections are agreed at different human rights instruments.²²

There is no reliable, up-to-date national statistics available on disability in Ethiopia. Ethiopia had its last national census in 2007. The census found out that there were 805,492 persons with disabilities in Ethiopia, which is about 1.09% of the then total population of 86 million. However, the 2011 WHO and World Bank joint publication on the world report on disability estimates that there were about 15 million persons with disabilities in the country that is about 17.6% of the then population.²³ The Central Statistics Agency of Ethiopia reported a total population of 82,101,998 in 2011.²⁴ This data is generally skewed by underreporting to most

²⁰ United Nation Convention on the Right of Persons with Disabilities (CRPD), adopted by General Assembly resolution 61/106 of 13 December 2006, available at <https://www.un.org/disabilities/default.asp?id=150> accessed on March 28, 2019.

²¹ Ayteneu, D., The rights of persons with mental disabilities to access mental healthcare and their human rights conditions in psychiatric facilities in Ethiopia.

²² Sexuality and Disability in the Indian context, working paper, TARISH 2018 available at <http://www.tarshi.net/inplainspeak/tarshis-corner-working-paper-sexuality-and-disability-in-the-indian-context-2018/> accessed on April 5, 2019.

²³ Disability Rights in Ethiopia; the situation of persons with disabilities. Sida , 2014 available at <https://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-ethiopia.pdf>. Accessed on May 24, 2019.

²⁴ Ethiopia, Definition, number and type of disability; Dutch Coalition in Disability and Development, 2019 available at <http://www.dccd.nl/lobby/definition-and-numbers-and-types/> Accessed on May 24, 2019.

commentators in the disability arena. Underreporting of disability may be due to negative attitudes, different interpretations and misconceptions of the word ‘disability’ and the exclusion of homeless disabled persons and generally lack of people involved in the census gathering and data analysis.²⁵ The data that were available are crude estimations of the total population of PWD rather than disaggregated by sex or types of disability that delineates the margin of the scope to which women with disabilities are represented. Lack of data and information on WWD hinders planning processes and the implementation of gender-responsive and disability-inclusive national strategies, policies and programs.²⁶

Thus defining disability and identification of the legal undertakings across several international and regional human rights instruments are vital.

2.2. Definition of Disability.

Disability as a concept is complex and multi-layered. As with any complex construct, there are always problems with definitions. Definitions by their very nature tend to be very limiting and often oversimplify ideas in their attempt to over clarify and focus. As the terminology also keeps changing evidenced by the shifts in language reflecting the politics of the day.

According to the WHO, disability is an umbrella term, covering impairments, activity limitations, and participation restrictions.²⁷ Impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while participation restriction is a problem experienced by an individual in involvement in life situations.

The International Classification of Functioning, Disability and Health (ICF) advanced the understanding and measurement of disability.²⁸ It construes disability into three interconnected area namely impairment, activity limitation and participation restriction. Disability therefore refers to difficulties encountered in any all three functioning areas.

²⁵Disability right, supra at note 23, pp12.

²⁶ [Situation of women and girls with disabilities, Supra at note 116??], paragraph 23 Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol, UN General Assembly , 2017, paragraph 21 available at ,201thereto<https://www.google.com/search?q=Gender+based+violence+in+reproductive+health+of+women+with+disabilities&aq=chrome..69i57.26644j0j8&sourceid=chrome&ie=UTF-8> accessed On May 23, 2019.

²⁷WORLD HEALTH ORGANISATION. Disabilities, Retrieved from <http://www.who.int/topics/disabilities/en/>, accessed on April 5, 2019.

²⁸ CRPD, supra at note 20 Preamble, par. (e)

The CRPD, the most pertinent instrument on disability, does not define the word ‘disability’; certainly, the Preamble acknowledges that ‘disability’ is an evolving concept.²⁹ It does not either define the term PWDs.³⁰ This may be because any definition would necessarily include some people and not others, and that over time, the definition may change in a way that would exclude people who may not now be considered as members of the group of PWDs which complies with the dynamic and evolving nature of disability. Moreover, by not including a specific definition of disability, the CRPD recognizes that a person may be considered as having a disability in one society, but not in another, depending on the role the person is assumed to take in his/her community and the barriers that limited him/her from participating in a given society.³¹

The CRPD resorts to state that:

“The term includes persons who have long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society.”³²

This evidences that no rigid view of the notion is imposed, which rather assumes a dynamic approach that allows for adaptations over time and within different socioeconomic settings. Hence, this is not an exhaustive definition of the subjects of the protection under the Convention; nor does this definition excludes broader categories of PWDs found in national law, including persons with short-term disabilities or persons who had disabilities in the past.

2.3. Definition of Reproductive Health

The purpose of defining reproductive health as human right is to acknowledge the fundamental importance of reproductive health in our society and to imbue reproductive health with the legal and ethical protection afforded human rights.³³ Several factors support the idea of considering reproductive health as a human right: its centrality to human functioning; its contribution to overall human health; its interconnectedness with numerous other human rights; and its relationship with social factors involving sexuality, gender, and power.³⁴ The terms ‘reproductive

²⁹Ibid.

³⁰Ibid.

³¹Aytenew D, *Supra* at note 21, pp16.

³²CRPD *Supra* note 20, preamble.

³³LOUIS HENKIN, *The Age of Rights*, 2003, pp 32 (discussing the development of international remedies for violation of ICCPR and ICESRC)

³⁴Lance Gable, *Reproductive Health as a Human Right*, Wayen State University Law School Legal studies Research paper No 10-20, June 2011

health’, ‘sexual health’, and ‘reproductive rights’ occur frequently together in scholarly articles and advocacy documents.³⁵ Although these three notions are distinct together they provide a complementary and comprehensive solution.³⁶ In short, reproductive health emphasizes the very necessary reproductive health services that a woman need. Reproductive right is based on universal legal protection for women and sees these protections as rights. Reproductive rights are also rooted in the practice and concepts of the field of reproductive health.³⁷

2.4. Conceptualizing Reproductive Health Right: Models of Reproductive Health Rights

Reproductive health right is positioned at the junction of two evolving models: the right to health model and the reproductive right model. The two models are not mutually exclusive and have salient common features. We can mention three important features. First they share the human right paradigm in that both are applied to human by virtue of their humanity and impose obligation on the government to uphold them and for their implementation. Second, they are interrelated with other human rights in the reproduction aspect and this interrelationship has a consequence to reproductive health. Third, both models encompass reproductive health right even though inception of reproductive health right in each model has a varying conception in each model. The variance in perspective between the models builds on the historical divergence between reproductive rights and the right to health.³⁸

Lance G., in his research paper describes the two models as reproductive right and right to health model. Reproductive right model are those discourses in which an individual right grounded in civil and political rights such as autonomy, privacy, liberty, and equality are protected and the decisional aspect of the human right to reproduction are upheld.³⁹

Right to health model is by contrast those rights developed primarily as an economic, social, and cultural right, with an attendant focus on the provision of affirmative access to health service and on guarantees to uphold the underlying determinants of health.

³⁵Mekedes Fisseha Libasie, Implementation of Women’s Right to Reproductive Health in Ethiopia; Policy and Health care perspective, 2016.

³⁶ A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice, Asian communities for Reproductive Health, 2005: <https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf> accessed April 28, 2019.

³⁷Lance G, supra at note 34, pp15.

³⁸Ibid, pp18.

³⁹ Ibid.

2.5. The International and Regional Legal basis of Reproductive Health Rights

The following section outlines the international legal basis for the rights that collectively constitute reproductive Health rights. In addition to referring to binding international and regional human rights instruments, reference will be made to non-treaty international and regional consensus documents. Reproductive rights are fundamental human rights. They embrace human rights that are already recognized in international, regional and national legal frameworks, standards and agreements.

2.5.1. Reproductive Health in the context of ICPD

The International Conference on Population and Development (ICPD) marked a substantial redefinition of reproductive health within international policy on health and development.⁴⁰ The ICPD meeting was convened to chart a way forward to drastically improve reproductive rights outcomes with a twenty year plan. The ICPD declaration and its Program of Action redefined reproductive health as a broad public health concern grounded in political, social and economic realities and conjoined with human rights.⁴¹ In its paragraph 7.2 Reproductive Health is defined as:

“...certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence as expressed in human rights documents....”⁴²

⁴⁰ Ibid.

⁴¹ Program of Action of the International Conference on Population and development. See International Conference on Population & Development, Cairo, Egypt, Sept 5-13, 1994 (hereinafter ICPD program of Action; see also Rebeka J. Cook, Bernad M. Dickens & Mahamoud F. Fathalla, Promotion of Research in Human Reproduction ; Global Needs and Perspectives, (1998), pp7.

⁴² ICPD, *ibid*.

The ICPD received widespread praise for representing a paradigm shift in the modern global conception of reproductive health, moving away from the prior focus on fertility and population control, and toward an approach that prioritized rights-based approaches to protecting reproductive health.⁴³ The ICPD, and its Program of Action, was influential in setting standards, and prompted the distinct treatment of concepts. The ICPD Program of Action provides a clear articulation of reproductive health as a human right and defines reproductive health ‘as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’. It elaborates upon this further by stating that ‘...reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so...’⁴⁴ Accordingly, it can be understood that substantive concepts of reproductive health go beyond the provision of healthcare services, to enabling individuals to exercise personal decisions and autonomy. Reproductive autonomy mainly concerns the individual aspects of a person’s destiny whereby the person is enabled to take control of their own biological destiny without being penalized.⁴⁵

The ICPD definition provides three features to the reproductive health. The first notable feature of the definition is that reproductive health consists of a complete physical and mental wellbeing in all matters related to reproductive functioning and processes. The second feature is that individual autonomy in reproductive matters and all of the enabling conditions necessary to exercise that autonomy with the emphasis that governments have a duty to create those enabling conditions. The third feature is that the definition of reproductive health includes the right to comprehensive reproductive healthcare.⁴⁶ The ICPD definition also includes sexual health the purpose of which is the enhancement of life and personal relation and not merely counseling and care related to reproduction and sexually transmitted diseases.

However, the ICPD’s failure to adequately clarify terms caused difficulties in proper conceptual understanding. The official delineation of these rights certainly remains critical and lasting

⁴³ Laura Reichenbach & Mindy Jane, *The Global Reproductive Health and Rights Agenda; Opportunities and Challenges for the Future*, in *REPRODUCTIVE HEALTH AND HUMAN RIGHTS* (2009) pp21.

⁴⁴ ICPD. *Supra* at note 41, par. 7.2.

⁴⁵ Loretta Feris, ‘The Right to Access Reproductive Health Care in the South African Constitution’, in Obioma Nnaemeka and Joy Ngozizi Ezeilo (eds.), *Engendering Human Rights: Cultural and Socioeconomic Realities in Africa* (Palgrave Macmillan, 2005) 83 [Emphasis added].

⁴⁶ Sneha Barot, *Looking Back While Moving Forward; Marking 20 Years since the ICPD*, GUTTMUSHER Institute, Vol 17. 3, 2014, pp4.

contribution of program of Action. However certain issues were left compromised. For example, although the document acknowledges the health impacts of unsafe abortion, it stops short of endorsing safe, legal abortion as a necessary strategy to prevent them. ICPD program of Action also recognizes right to reproductive health information and services that safeguard privacy and confidentiality, yet it does not call for the removal of mandatory parental consent polices.⁴⁷

In addition, the 1995 Fourth World Conference on Women (FWCW), which adopted reproductive rights issues as one of its main agenda items, did not further define these concepts beyond those already stated as definitions by the ICPD. As a result, concepts of reproductive health and reproductive rights were at risk of being construed as political rhetoric lacking any legal force. One of the notable pitfalls of these two conferences is that both conferences and the plan of action just outlined other rights that can constitute reproductive and sexual health but did not conspicuously acknowledge that sexual and reproductive health form part of the highest attainable standard of physical and mental health as ascribed in the notion of the ICESCR. However, with the emergency of the Maputo Protocol and deliberation of different UN committee's comments asserts that reproductive health constitutes element of the right to health.

2.5.2. The Protocol to the African Charter on the Rights of Women in Africa (the Maputo Protocol)

The protocol⁴⁸, which resulted from years of activism by women's rights supporters in the region, has attempted to reinvigorate the African Charter's commitment to women's equality by adding rights that were missing from the Charter and clarifying governments' obligations with respect to women's rights. Only one out of the more than sixty articles in the African Charter makes specific reference to women.⁴⁹ The following are key shortcomings of the Charter as it pertains to women:

- Its failure to explicitly define discrimination against women;
- Its lack of guarantees to the rights to consent to marriage and equality in marriage; and

⁴⁷ Ibid.

⁴⁸The Protocol to the African charter on Human and Peoples Right on the rights of Women in Africa here in after the Maputo protocol, Adopted July 11, 2003 and entered into force.

⁴⁹Mekedes F, Supra at note 35, pp27.

- Its emphasis on traditional values and practices that have long impeded the advancement of women's rights in Africa.

The Maputo Protocol is particularly strong on women's reproductive rights, and is a tool for ensuring universal access to reproductive health and the creation of an enabling environment. It goes beyond other binding treaties, such as CEDAW, in outlining reproductive rights.⁵⁰ The Maputo Protocol takes an undeniable normative step forward by making substantive rights of women unequivocally binding.⁵¹ It contains the first references to HIV/AIDS in an international treaty, and the first expression of a right to abortion, albeit limited to where a pregnancy is the result of sexual assault, rape, or where it endangers a woman's mental or physical health. It specifically recognizes marital rape as a form of gender-based violence. Moreover, the protocol “identifies protection from HIV and AIDS as a key component of women's sexual and reproductive rights”.

Article 14 of the Maputo Protocol under its heading ‘Health and Reproductive Rights’ states that state parties shall ensure; the right to health of women, including SRHR is respected and promoted. This includes: (a) the right to control fertility; (b) the right to decide whether to have children, the number of children and spacing of children; (c) the right to choose any method of contraception.. (d) the right to have family planning education...

In adopting the terms ‘reproductive health’ and ‘sexual health’ in its text, the Protocol bestowed on them a legal force. Prior to this, numerous treaties had taken an indirect approach by recognizing the rights as indispensable to ensure the right to reproductive health and elaborating upon them through treaty bodies.

Cumulative reading of Article 14(1&2) of the Maputo Protocol set out three major components of women's reproductive health rights:

- i. Reproductive and sexual decision making, including the number and spacing of children, contraceptive choice, and the right to self-protection from HIV;
- ii. Access to information about HIV/AIDS and reproductive health; and

⁵⁰ Convention on the Elimination of All Form of Discrimination Against Women, 1979, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/46, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) Art 12.

⁵¹Frans Viljoen, An introduction to the Protocol to the African Charter to Human and Peoples right, 2009 available on <http://law2.wlu.edu/deptimages/Journal%20of%20Civil%20Rights%20and%20Social%20Justice/Frans%20Viljoen.pdf> accessed on May 4, 2019

- iii. Access to reproductive health services, including antenatal services and abortion-related services.

Some scholars, however, argue that Article 14 could be construed notably narrowly or is over specific in the sense that for example it demands offering access to any form of contraception or requiring state parties to establish pre and post natal nutritional services to women. Thus, it will limit the effective implementation of these rights as the vagueness of the provision on how these goals should be implemented creates problem.⁵²

The Maputo Protocol has also given attention to women that had precarious position and are vulnerable including disability.⁵³ It addresses multiple oppressions that some women face on the grounds of gendered as well as disability. Maputo Protocol also reiterates the concept of positive measures by favoring women over men.⁵⁴ Pre-empting arguments based on formal equality, the protocol requires states to adopt measures that may favor women above men in order to ensure substantive ('in fact') equality. The Maputo protocol is consistent with existing Ethiopian laws and with the country's foreign and domestic policy objectives. The protocol would also help efforts to enhance Ethiopian laws with respect to discrimination and violence against women, access to legal protections, and other human rights of women.⁵⁵

2.5.3 The ICESCR, CEDAW and Other Related UN Body Instruments.

Since the late 1990s, the notion of reproductive health has been contained within the right to health in different international human right soft laws and non-binding treaties. The interpretations of these rights therefore have not been prominently acknowledged as obligatory. Nevertheless, the fact that they have been echoed on a number of occasions and their sources, make these interpretations highly persuasive.⁵⁶ The ICESCR does not directly dwell on the reproductive health rights except Article 12(a) of the convention which only deals with the right

⁵²VANDER BILTS, Is the emperor still naked? Why the protocol on the Rights of women in Africa leaves women in Africa to more discrimination, Vol. 42. 2009, pp18.

⁵³Maputo Protocol Supra at note 48, Article 23.

⁵⁴Maputo Protocol , Supra note 48, Article 9(1).

⁵⁵FanaHagos, Why should Ethiopia ratify the Maputi Protocol, 2010 available at <https://www.pambazuka.org/governance/why-ethiopia-should-ratify-maputo-protocol>. Accessed on May 29, 2019.

⁵⁶Mekedes. F, supra at note 35, pp43.

to maternal, child and reproductive health.⁵⁷ Henceforth, consulting the general comment regarding reproductive health is an eclectic option to unveil the issue effortlessly. General Comment Number 22 of Article 12 of the ICESCR was issued in light of constant, severe violations of the right to sexual and reproductive health care, and focus on the various barriers that impede enjoyment of this right.

General Comment 22 identifies four central characteristics of sexual and reproductive health care: availability, accessibility, acceptability (respectful of and sensitive to patients' particular identities and needs), and quality. The Committee emphasizes that sexual and reproductive health is interrelated with other rights, including education and non-discrimination, and has been disproportionately and discriminatorily denied to certain vulnerable groups, including persons with disabilities and lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals.⁵⁸ Inference from the above statement is that persons with disabilities including women with disabilities are included in the category. Paragraph 26 of the General Comment albeit its reaffirmation to paragraph 34 of General Comment Number 5 of ICESCR⁵⁹ for the physical and mental health issue of persons with disabilities in the context of physical and mental health, it did not add any significance and is short off to address the social wellbeing of people with disabilities. Exhaustive reading of this paragraph only suggests a means of combating health discrimination against women.⁶⁰ Although this is a welcome approach, it appears fragmented and seems to connote that 'reproductive health' and 'sexual health' is tools rather than their own ends.⁶¹

The promulgation of General Comment 14⁶² and the activities of the Special Rapporteur⁶³, taking the vague language of Article 12 of the ICESCR, produced a detail explanation of what right

⁵⁷ General comment No.22 (2016) on the right to sexual and reproductive health, (Article 12 of the International Convention on Economic, Social and Cultural Rights).

⁵⁸ CESCR issues guidance on right to sexual and reproductive health, 2016 available at <https://ijrcenter.org/2016/03/16/the-cescr-addresses-the-right-to-sexual-and-reproductive-health/> accessed on April 23, 2019

⁵⁹ General Comment No.5 (1994) on Persons with Disabilities. U.N. Doc E/1995/22 at 19 (1995), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 24 (2003).

⁶⁰ See General Comment 22, supra note at 57.

⁶¹ Mekedes F, supra at note 35, pp44.

⁶² CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4)

protections are actually required under the right to health. It also added that reproductive health is an integral part of the right to health.⁶⁴ Cumulative reading of paragraph 8, 18 and 21 indicates that the protection of these rights guarantees the protection of reproductive health rights. The Special Rapporteur elucidates this as, ‘the right to control one’s health and body’ arises from the right to health as well as from the right to freedom from discrimination and cultural practice linked with reproductive harmful cultural practices linked with reproductive health risks. The rapporteur has also found out that in the context of reproductive health, rape, female genital mutilation and other forms of sexual violence, forced pregnancy, non-consensual contraception like forced sterilization and abortion, forced marriage and child marriage are fundamentally and inherently inconsistent with the right to health.

The general comment also added entitlements that are created by the right to health to include adequate system of health protection and evokes measures such as improving child and maternal health, sexual and reproductive health services, including access to family planning, pre and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act to that information.⁶⁵

The CEDAW⁶⁶ committee also recognizes reproductive health as part and parcel of the right to health. Under Article 16.1.e of the Convention include health-related rights guarantees including the right to decide on the number and spacing of children, but that is only one of the articles that address women's rights in relation to health. Article 12 is central. It formulates States parties' obligation "to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."⁶⁷ Access to vital health services such

⁶³UN ECOSOC, communication on Human Rights, Report of the special rapporteur: The right of everyone to the Enjoyment of the Highest Attainable standard of Physical and Mental Health, UN. Doc. E/CN/4/49,2004(prepared by Paul Hunt) herein after Special Rapporteur Report

⁶⁴Commission on Human Rights Resolution: 2004/27 states: ‘Considering that sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, available at: <http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2004-37.doc> accessed May 11, 2019.

⁶⁵General Comment 22, supra at note 57, par 14.

⁶⁶Convention on the Elimination of all form of Discrimination Against Women, 1979, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/46, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981).

⁶⁷Ibid , Article 12(a).

as voluntary testing, counseling and treatment for sexually transmitted infection including HIV/AIDS, reproductive system cancer and infertility treatments were required.⁶⁸

It should be noted that, among the six human rights treaties in the United Nations system, the Women's Convention and the Convention on the Rights of the Child (CRC) are the only ones to mention family planning.⁶⁹ In addition to the aforementioned articles, the right of access to specific educational information and advice on family planning is guaranteed under Article 10.h of this Convention. Article 14.b specifies the right of women in rural areas to have access to adequate health care facilities, including information, counseling, and services in family planning. In Article 11.f, the Convention also refers to the right of women to the protection of health and to safety in working conditions, including "the safeguarding of the function of reproduction." Many other provisions of the Convention have an implicit or indirect bearing on women's rights in relation to health, some of which have been explicated in the General Recommendations of the CEDAW Committee in relation to female genital mutilation, sexual violence, HIV/AIDS, and reproduction.⁷⁰ Most recently, a General Recommendation on women and health has elaborated the Committee's understanding of Article 12 of the Women's Convention, addressing the obligations of States parties to eliminate discrimination and to respect, protect, and fulfill rights relating to women's health throughout the life span.⁷¹ In its General Comment 24, the CEDAW's Committee interpreted Article 12 of the CEDAW in underlining how women's health is highly interlinked with reproductive issues.⁷² The Committee also suggested that governments' should implement national action strategies as follows:

“States Parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both

⁶⁸General comment 14 Supra at note 62, par 29.

⁶⁹ Convention on the Rights of the Child, adopted Nov. 20, 1989, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989), reprinted in 28 I.L.M. 1448 (entered into force Sept. 2, 1990); Other Conventions do not provide the reproductive health rights components-family planning, explicitly.

⁷⁰ Carmel Shavel, Rights to Sexual and Reproductive Health, The ICPD and Convention on the elimination of all forms of discrimination against women, 2000 available at <file:///C:/Users/hani/Desktop/rt%20of%20sexual%20and%20reproductive%20health%20harvard%20Uni.pdf>, accessed May 2, 2019.

⁷¹ Committee on the Elimination of Discrimination against Women, General Recommendation 24, Women and Health (Twentieth session, 1999), U.N. Doc. A/54/38 at 5 (1999), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

⁷² General comment 24, Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008)

the prevention and treatment of diseases and conditions affecting women...including sexual and reproductive health services”⁷³.

Paragraph 25 of the general recommendation deals specifically with reproductive health rights of WWD of all ages.⁷⁴One can infer from this paragraph that the committee only refers to physical accessibility in which the conception of accessibility is precluded to availability of the service rather than the dimensions such as non -discrimination, economic and information accessibility. The inkling of the last statement of the paragraph on the measures to ensure that health services are ‘sensitive to the needs of women with disabilities and are respectful of their human rights and dignity’.is vague since the term sensitive is more subjective to set thresholds of the needs of WWDs.

Another noticeable works of the CEDAW committee regarding the reproductive rights of women with disabilities include General Recommendation No. 18, which considers Article 3 of the convention that guarantees basic human rights and fundamental freedoms and recalls that women with disabilities are considered as a vulnerable group under the heading “areas of special concern”. The committee recommends that States parties provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life.

2.6. Normative Contents of the Right to Reproductive Health

For the consumption of this thesis, it is plausible to meticulously deal with each of the reproductive health normative components. The following portion of this chapter deals with each component of the reproductive health as to the relevancy and applicability of the right to reproductive health of women with disabilities.

⁷³ Ibid, par 29 and General Recommendation 24 of CEDAW Committee, par 24.

⁷⁴ Paragraph 25 reads as ‘*Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity*’.

General comment 14 of ICESCR lists out under paragraph 12 the four interrelated and essential elements of the right to health. If reproductive health is regarded as part of the right to health, then it follows that the interrelated and essential elements that are necessary for the implementation of the right to health will also apply to reproductive health.⁷⁵ Even if this general comment has only partly addressed the issue of reproductive health, partly grave violations of reproductive health rights continue and therefore the Committee concedes the issue deserves a separate general comment. Following, the General comment number 22 of the ICESCR was promulgated. The normative content of the right to health is dealt thoroughly under part three. These elements are dealt below:

i. Availability

Availability describes the existence of an adequate number of functioning healthcare facilities, services, goods and programs to provide the population with the fullest possible range of sexual and reproductive health care.⁷⁶ It also refers to the existence of infrastructure, goods and service related to reproductive health care such as ensuring the availability of facilities, goods and services to guarantee of the underlying determinants of the realization of the right to sexual and reproductive health. The availability for trained medical and professionals, skilled providers shall mean to construe those personnel who are translators in the case of hearing impairment.

ii. Accessibility

Accessibility in general refers to the need for reproductive health care to be accessible and open to all individuals and groups, which includes women with disability. The committee considers four overlapping dimensions alike the General comment 14. These dimensions are; Accessibility without discrimination, *physical accessibility*, *affordability* and *information accessibility*.

Physical Accessibility; this accessibility dimension extends to all.⁷⁷ In an open ended listing the paragraph considers people with disability as a disadvantaged and marginalized group. Physical accessibility encompasses safety and a reasonable distance to health facilities, goods, information and services related to sexual and reproductive health care. States shall take positive

⁷⁵Mekedes F, Supra at note 35, pp48.

⁷⁶General comment No. 22 ,on the right to sexual and reproductive health on article 12 of the ICESCR, 2016, par 12.

⁷⁷General Comment 22, supra at note 57, par 16.

measures to ensure equality by providing communication and transportation in case of distance to these rights.

Economic Accessibility; Sexual and reproductive health services must be economically affordable for all. This accessibility requirement extends beyond essential goods and services to other determinants of sexual and reproductive health like water and nutrition. For example, women in developing countries tend to be less economically empowered, and services should take into consideration the means of poorer women.

Information accessibility; Information accessibility is a bidirectional in that it includes the right to seek, and receive by individuals of all sexual and reproductive health information and ideas generally and specifically related to their health status in one hand and the dissemination of evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post abortion care, infertility and fertility options, and reproductive cancer by the provider. Information should be provided for people in the manner and language suitable to their understanding and culture; hence information should be tailored to reach to women in disability with a suitable communication channel such as brail, sign language or any communication assistive device.

iii. Acceptability

Acceptability is about being mindfulness of the culture of the reproductive health needs of the individual. The practices employed at the health facilities, goods, and services rendered must be respectful of the culture of individuals, minorities, peoples, and communities. Reproductive health themes could be particularly sensitive subjects in many cultures. Caution must be taken to make these services digestible to the people and the culture.⁷⁸

iv. Quality

The quality and acceptability of facilities, goods, information and services related of sexual and reproductive health should be evidence-based and scientifically and medically appropriate and up-to-date. While providing these services the government should also ensure that the

⁷⁸Mekedes F, Supra at note 35, pp48.

medication and procedures incorporate technologically advanced and recent innovations that do not jeopardize the quality of care.

The General comment has put the issue of *non-discrimination and equality* in its section ‘*B of special topic of broad application*’.⁷⁹ States should ensure non-discrimination and equality to women with disabilities. Any legal and factual element that impede the accessibility, availability, acceptability and quality in the provision of sexual and reproductive healthcare as well as its barriers.

It provides

‘Non-discrimination and equality require not only legal and formal equality but also substantive equality. Substantive equality requires that the distinct sexual and reproductive health needs of particular groups, as well as any barriers that particular groups may face, be addressed. The sexual and reproductive health needs of particular groups should be given tailored attention. For example, persons with disabilities should be able to enjoy not only the same range and quality of sexual and reproductive health services but also those services which they would need specifically because of their disabilities. Further, reasonable accommodation must be made to enable persons with disabilities to fully access sexual and reproductive health services on an equal basis, such as physically accessible facilities, information in accessible formats and decision-making support, and States should ensure that care is provided in a respectful and dignified manner that does not exacerbate marginalization’⁸⁰.

2.7. State’s Obligation to the Reproductive Health Rights under the International and Regional Frameworks.

Through ratifying human rights treaties, States consent to be bound by these treaties and must comply with their provisions in good faith.⁸¹ Domestic laws that conflict with treaty provisions cannot be used to justify non-compliance.⁸² States have specific legal obligations to respect, protect, and fulfill the rights protected in these human rights treaties. These obligations include both limitations on the actions that States may take (negative obligations) and proactive

⁷⁹ General comment 22, supra at note 57, par 25.

⁸⁰Ibid.

⁸¹ Vienna Convention on the Law of Treaties (1980) Article 26.

⁸²Ibid, Art 27.

measures that States must take (positive obligations). States must take steps towards fulfilling their obligations by all appropriate means, including particularly the adoption of legislative measures, and should report on these measures and the basis on which they have been considered the most “appropriate” under the circumstances.⁸³ Some State obligations, including civil and political rights obligations and core economic, social and cultural rights obligations are of immediate effect while others are subject to progressive realization.

The CESCR impose three different types of obligations on States: the obligations to respect, protect, and fulfill which are referred as the ‘tripartite typology’.⁸⁴ Typologies suggest that each human right imposes a variety of obligations classified by different ‘types’ or ‘levels’. They are analytical tools that explain that the complete fulfillment of each right requires the performance of multiple kinds of duties.

The *duty to respect* requires States to refrain from interfering directly or indirectly with the enjoyment of reproductive rights. The *duty to protect* requires States to prevent third parties from infringing on reproductive rights and to take steps to investigate and punish such violations when they occur. The *duty to fulfil* requires that States adopt whatever measures necessary—legislative, budgetary, judicial, and/or administrative—to achieve the full realization of reproductive rights.

As part of their obligations, States must ensure that reproductive health information, goods, and services are available, accessible, acceptable, and of good quality (AAAQ) in order for States to meet their obligations to respect, protect, and fulfill reproductive rights.⁸⁵

The General Comment number 22 has detailed general, specific, and core obligations of State parties to ensure that individuals can fully enjoy their right to sexual and reproductive health. The general obligations included maximizing available resources and eliminating discrimination against certain groups and individuals, whereas the specific legal obligations placed the State party under the obligation to respect, protect and fulfill the right to sexual and reproductive health.⁸⁶

⁸³Committee on Economic, Social and Cultural Rights, General Comment No. 3: The nature of States parties’ obligations (Art 2, para. 1), pp 2-4 (1990), U.N. Doc. HRI/ GEN/1/Rev.9 (Vol. 1), at 7 (2008)

⁸⁴Mekedes F, Supra at note 35, pp27.

⁸⁵ General comment 14, Supra at note 62, par 12.

⁸⁶ Ibid, par 40.

The Committee also listed seven core obligations of the State party to ensure the satisfaction of the right to sexual and reproductive health.⁸⁷ These core obligations included: eliminating laws and policies that criminalize or undermine individual's or specific groups access to sexual and reproductive health facilities, services, and information; adopting a national strategy on sexual and reproductive health; guaranteeing access to quality sexual and reproductive health services, goods, and facilities; enforcing and enacting legal prohibition of gender-based violence, including female genital mutilation and forced marriages; taking active measures to prevent unsafe abortion; ensuring a comprehensive education on sexual and reproductive health absent of discrimination; providing essential medicines and medical equipment needed for sexual and reproductive health; and ensuring access to effective remedies and redress for violations of the right to sexual and reproductive health.⁸⁸

As mentioned in the last core obligation, if the State has violated the right to sexual and reproductive health, State parties must ensure that individuals have access to an effective remedy.⁸⁹ Some of the remedies for a violation may include adequate restitution, compensation, rehabilitation, and assurances of non-repetition.⁹⁰

This section will discuss on four interrelated freedoms of reproductive health rights that states are under obligation. These freedoms are selected on the relevance and application to women in disabilities rather than their level of importance, as all freedoms are equal and interdependent.

These are: (1) *the right to equality and non-discrimination*; (2) the right to marry and found a family; (3) *the right to reproductive health, including family planning and maternal health services, information, and education*; and (4) *the right to be free from Gender based violence*.⁹¹

These rights are protected under a number of widely ratified international human rights treaties that create binding legal obligations upon the states that are parties to them. In addition, UN conferences have resulted in international agreements concerning reproductive rights. While not binding in the same way as treaties, these consensus documents are evidence of states' acknowledgement that they must take specific measures to ensure that reproductive rights are

⁸⁷ Ibid, par 49

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ Ibid, par 64.

protected, respected, and fulfilled.⁹² Similarly, there are a variety of specific international consensus documents addressing the rights of women with Disabilities and states' commitments to realizing them. These are resolutions of the United Nations General Assembly, including: the Declaration on the Rights of persons with Disabilities,⁹³ the Standard Rules on the Equalization of Opportunities for Persons with Disabilities,⁹⁴ and World Programme of Action Concerning Persons with Disabilities.⁹⁵

a. Obligation under Non Discrimination and Equality

The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation. States must ensure the enjoyment of their sexual and reproductive health and rights without any form of discrimination.⁹⁶ Discrimination can be both a cause and consequence of sexual and reproductive health-related concerns.⁹⁷ Women with disabilities are often more likely to encounter discrimination in the enjoyment of their sexual and reproductive rights.⁹⁸ Discrimination in the context of sexual and reproductive health can contribute to unequal access to health services, delays in or denials of sexual and reproductive health care, or abusive treatment in the provision of sexual and reproductive health services.⁹⁹ States must achieve both formal and substantive equality for women by ensuring the

⁹²Reproductive rights and Women with Disabilities, Center for Reproductive Health Rights, 2002 ,pp 7 available at <https://www.reproductiverights.org/document/reproductive-rights-and-women-with-disabilities-a-human-rights-framework>, accessed May 13, 2019.

⁹³ Declaration on the Rights of Disabled Persons, proclaimed Dec. 9, 1975, para. 1, G.A. Res. 3447(XXX), available at <https://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfDisabledPersons.aspx>.

⁹⁴ Universal Declaration of Human Rights, 14 January 2002 adopted Dec. 10, 1948, art. 16, para. 1, G.A. Res. 217A(III), available at <http://hrlibrary.umn.edu/instreet/b1udhr.htm> accessed on May 13 , 2019.

⁹⁵World Programme of Action Concerning Disabled Persons, adopted Dec. 3, 1982, para. 74, G.A. Res. 37/52, U.N. GAOR<https://www.equalrightstrust.org/sites/default/files/ertdocs/world%20program%20of%20action%20on%20disabled%20persons.pdf> accessed May 13, 2019.

⁹⁶ Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities, Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women ,2018, paragraph 2 available at <https://www.ohchr.org/Documents/HRBodies/CRPD/Statements/GuaranteeingSexualReproductiveHealth.DOCX> accessed on May 13, 2019.

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Ibid.

provision both in law and in practice of distinct reproductive health services that attend to specific needs, such as those required by women during and after pregnancy.

States have an obligation to develop laws, policies, and practices to ensure equal treatment and freedom from discrimination in the context of sexual and reproductive health and rights, with immediate effect.¹⁰⁰ This requires that: Sexual and reproductive health information, goods, and services are accessible to all in law and practice without discrimination. This includes the obligation to:

- ✓ Eliminate direct and indirect discrimination and take measures to ensure both formal and substantive equality in laws, regulations, policies, and practices with respect to sexual and reproductive health information, goods, and services.¹⁰¹
- ✓ Ensure that reproductive health information, goods, and services that only women require are available, accessible, acceptable, and of good quality¹⁰².

States adopt measures to achieve equality and eliminate discrimination with respect to sexual and reproductive health for all.¹⁰³ This includes the obligation to:

- ✓ Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights¹⁰⁴ to combat stigma and discrimination amongst health care professionals.
- ✓ Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice.¹⁰⁵
- ✓ Ensure adequate allocation of funding to policy implementation across regions to eliminate disparities in availability, accessibility, acceptability, and quality of sexual and reproductive health services.¹⁰⁶

¹⁰⁰See Protocol to the African Charter on Human and Peoples' Right on the Rights of Persons with Disabilities in Africa, 2018; see also UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendations Nos. 16, 17 and 18, adopted at the Tenth Session, 1991 (contained in Document A/46/38)*, 1991, A/46/38, available at: <https://www.refworld.org/docid/453882a322.html> [accessed 29 May 2019]

¹⁰¹CEDAW supra note at 44 Article 10(h), 16(1), (e) and General comment 24, supra at note 63 paragraph 8

¹⁰² General Recommendation 24, supra at note 66, Paragraph 14.

¹⁰³Committee on the Elimination of Discrimination against Women, General Recommendation No. 25: Article 4, paragraph 1 of the Convention (Temporary special measures), 2004, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 365 (2008) [hereinafter General Recommendation No. 25].

¹⁰⁴ General Recommendation 14, supra at note 62, par 31(f).

¹⁰⁵ Ibid, Par 31(e); and Maputo Protocol, Art 14 (1).

¹⁰⁶ CEDAW, supra note at 66, Art 11(2).

b. Obligation under the right to reproductive health, including family planning and maternal health services, information and education

Women's and adolescents' ability to make autonomous decisions about whether and when to have children through access to available, acceptable, and good quality contraceptive information and services is critical for achieving gender equality and ensuring that they can participate as full members of society.¹⁰⁷ Yet, despite desires to avoid or delay pregnancy, roughly 222 million women in developing countries rely on either traditional methods—periodic abstinence or withdrawal—which have high failure rates, or do not use any contraceptive method at all.¹⁰⁸

States have an obligation to ensure that any law, policy or practice to access to family planning, contraceptive information and services and sexual education are not both *dejure* and *defacto* discriminatory, corrosive, or violent. This requires that:

- ✚ States take steps to ensure that all individuals have access to comprehensive, scientifically accurate, unbiased information regarding contraceptive methods.¹⁰⁹ The obligation to ensure that health care providers are trained to provide scientifically accurate information and counseling on a full range of contraceptive methods,¹¹⁰ and that information is available in a language and format that is understandable by women with disabilities.
- ✚ States take steps to ensure a full range of contraceptive methods¹¹¹ are available, accessible, acceptable, and of good quality.¹¹² This includes the obligation to ensure: alternative contraceptive methods that are tailored to the needs of the woman with disabilities. States shall also ensure public and private health facilities offer a full range of contraceptive methods that are responsive to the needs of different women with disabilities and that such methods are intermittently available and are free of charge or are cheaper in cost by state subsidization.¹¹³

¹⁰⁷ Reproductive Right, supra at note 92, pp13.

¹⁰⁸ Ibid.

¹⁰⁹ Committee on the Elimination of Discrimination against Women, General Recommendation No. 21: Equality in Marriage and Family Relations, 1994, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 337 (2008).

¹¹⁰ CEDAW Committee, Concluding Observations: Hungary, paragraph 33, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

¹¹¹ Reproductive Right, Supra at note 92, pp15.

¹¹² General comment 14 Supra at note 62, par 12(b)(iii).

¹¹³ Reproductive Right, Supra at note 92, pp15.

- ✚ States take steps to ensure that women with disabilities make free and fully informed and consented decision according to their choices of family planning methods. Therefore states should develop proper communication channel, format or alternative media to raise public awareness about the importance of contraceptive use.¹¹⁴
- ✚ States collect, analyse, and disseminate disaggregated data to better understand and monitor unmet need for modern contraceptive methods, contraceptive use, and primary barriers to accessing contraceptive information and services.¹¹⁵

Women and girls with disabilities face significant mistreatment and violence in the provision of reproductive health care, including in facility-based childbirth.¹¹⁶ There are multiple aspects and factors that resulted the mistreatment and violence against these women such as stereotypes about the sexuality of women with disabilities, their ability to parent, and their ability to make decisions for themselves, as well as a range of accessibility barriers (including physical, communications, information, and financial) and lack of provider training about their rights. The mistreatment and violence women with disabilities face as part of their reproductive health care, including in childbirth facilities, not only impacts their physical and emotional well-being but also deters some women with disabilities from seeking needed antenatal and postnatal care, putting their health and lives at risk.¹¹⁷

Both the CEDAW and ESCR committee have acknowledged that WWD have a right to physically accessible, disability sensitive and non-discriminatory maternal health services.¹¹⁸ CRPD also deals with the maternal health services in its

This requires:

- ✚ States must ensure that WWD should be assisted appropriately in their performance of child rearing responsibility. The state must also guarantee that these women are not separated on the basis of disability of either the mother or child or both.¹¹⁹

¹¹⁴ Protocol on the Disability, supra at note 100, Article 17(2)(e), Human Rights Committee, Concluding Observations: Guatemala, par 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); Dominican Republic, par 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012).

¹¹⁵ General Recommendation 24, Supra at note 72 , par 9.

¹¹⁶ Women Enabled, Submission to the Special Rapporteur on Violence against Women, its Causes and Consequences: Mistreatment of and Violence against Women and Girls with Disabilities in Reproductive Health Care, Including Facility-based Childbirth, 2019, pp2, available <https://www.womenenabled.org/violence.html> accessed on May 28, 2019.

¹¹⁷ Ibid.

¹¹⁸ General comment 22 Supra at note 57, par 16 and 45.

¹¹⁹ CRPD, supra at note 20, Article 23.

- ✚ State must also ensure WWD are not discriminatorily denied certain health care services and that services are located “as close as possible to people’s own communities, including in rural areas.”¹²⁰

c. The obligation for the right to be free from Gender based violence

Women and girls with disabilities experience gender-based violence at disproportionately higher rates and in unique forms owing to discrimination and stigma based on both gender and disability.¹²¹ Gender based Violence here in after called GBV is defined under CEDAW Art 1 as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life’. General Recommendation 19¹²² and General Recommendation 35¹²³ of CEDAW cumulatively emphasizes the concept as violence based on gender which in turn construes to the cause and impact of violence to be implicitly gender. When a women’s right is violated based on her gender; the violence can poses a significant barrier to her enjoyment of sexual and reproductive health rights.¹²⁴ GBV against women impedes to the enjoyment and entitlement of a women’s fundamental human rights that are a result of discrimination on her gender within the meaning of the CEDAW convention Article 1. General recommendation paragraph 7 lists these fundamental rights and freedoms including a) The right to life; (b) The right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment; (c) The right to equal protection according to humanitarian norms in time of international or internal armed conflict; (d) The right to liberty and security of person; (e) The right to equal protection under the law; (f) The right to equality in the family; (g) The right to the highest standard attainable of physical and mental health; (h) The

¹²⁰ Ibid, Article 25.

¹²¹ Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol, UN General Assembly, 2017, paragraph 21 available at <https://www.google.com/search?q=Gender+based+violence+in+reproductive+health+of+women+with+disabilities&aq=chrome..69i57.26644j0j8&sourceid=chrome&ie=UTF-8> accessed on May 23, 2019.

¹²² UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 19: Violence against women, 1992, available at: <https://www.refworld.org/docid/52d920c54.html> accessed on May 23, 2019.

¹²³ UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 35: Gender based Violence Against, 2017, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_35_8267_E.pdf

¹²⁴ Reproductive Right, Supra at note 92, pp28.

right to just and favorable conditions of work. The sexual or domestic violence results in unintended pregnancy, STI and pregnancy related complications.

When WWD are subjected to gender based violence their ability to control their fertility and may be impaired and reproductive autonomy and ability to sexual and reproductive health services will be compromised. Forms of gender based violence against WWD in the area of reproductive health include and not limited to forced reproductive health intervention, mistreatment or abuse in the maternal health setting , Harmful traditional practices such as Female genital mutilation, forced and early marriage, sexual harassment , removal of child from the parent. The violence may take multiple forms including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological or economic harm or suffering to women threats of such acts harassment, coercion and arbitrary deprivation of liberty.¹²⁵ Article 2 of the CEDAW convention urges for states to pursue by all appropriate means and without delay a policy to eliminate GBV against women. This obligation is of an immediate nature and has laid two aspects of responsibilities on the government's action or omission that fallout in violence from one the state party or actors and from non-state actors. The obligation includes:

- ✚ The obligation to develop laws , policies and practices to prevent, punish and eliminate violence against women in both public and private spheres¹²⁶
- ✚ The obligation to respect that the state or its actors shall refrain from any act or practice that is directly and indirectly discriminate women and ensure its actors act inconformity with this obligation.¹²⁷
- ✚ Take necessary legislative measures to prevent all forms of violence against women, including female genital mutilation, marital rape , and so called 'honor killing ;¹²⁸
- ✚ Exercise due diligence to investigate and punish the perpetrators of violence against women including prompt, thorough, impartial investigations on serious allegations and bring the offenders to justice.¹²⁹

¹²⁵General Recommendation 35 of CEDAW Supra at note 123, par 14.

¹²⁶ General Recommendation 19 of CEDAW, supra at note 122 and General Recommendation 35, supra at note 123.

¹²⁷ CEDAW Supra at note 44, Article 2(d) , General Recommendation 35, supra at note 117, par 22.

¹²⁸ General Recommendation 19, supra at note 116, Par 122 and General Recommendation 35, supra at note 123 par 34.

¹²⁹A.T. V Hungary CEDAW Committee No2/2003, U.N. Doc . CEDAW/C/32/DD/2/2003, 2005 available at <https://www.un.org/womenwatch/daw/cedaw/protocol/decisionsviews/CEDAW%20Decision%20on%20AT%20vs%20Hungary%20English.pdf> accessed on May 23, 2019

- ✚ Provide victims of violence with access to justice, including free legal aid where necessary in order to ensure available, effective and sufficient remedies, including compensation and rehabilitation.¹³⁰

Conclusion

Persons with disabilities consist about 15% of the world population, a significance portion of this percentile living in developing countries. The concept of PWD and the respect and promotion of their rights have evolved through time by prominent right activities and PWDs. Disability is not defined in any document as it is an evolving concept. Article 1 of CRPD resorts to state persons with disabilities as *‘persons with disabilities 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 basis with others’* While a wide range of factors that exclude PWDs exist, sexual and reproductive health (SRH) rights are amongst the major social factors that have seen PWDs being worse marginalized. The marginalization and seclusion of WWD is a double violation of their right to Reproductive health. The ICPD and its plan of Action made a paradigm shift in the modern global conception of Reproductive health towards prioritizing rights-based approaches to protecting reproductive health. Defining reproductive health in the human rights approach imbues the legal protection and ethical considerations afforded to it.

Numerous international and regional instruments have discoursed on the human right approach to RHR. The ICESCR, CRPD, CEDAW and Maputo Protocol have been the legal bases to argue the substantive concepts are beyond health care services enabling individuals to exercise individuals personal decisions and autonomy. The ratification of Maputo Protocol is a significant advancement for the rights of WWD in Ethiopia. Maputo Protocol takes an undeniable normative step forward by making substantive rights of women unequivocally binding. General comments Recommendation and concluding observations of CEDAW and ICESR committee are deeply scrutinized with respect to the RHR of WWD. The normative contents of RHR such as AAAQ and the element of non-discrimination and equality are entertained with each substantive elements inline to RHR. The chapter windup with the obligation of states to respect, protect,

¹³⁰Ibid, the committee forwarded in its communication part II (e), (f), and (g) lists this obligations.

fulfill to RHR of WWD enshrined within the international instruments and soft laws. The obligation of state is based on General comment 22 and analysis was made on three interrelated rights, equality & non-discrimination; right to RH, Family planning & maternal health services, information and education; and the right to be free from gender based violence.

Chapter Three

3. The Ethiopian Legal and Institutional Framework

The Ethiopian government has taken a number of stepping stones in the protection and promotion of the rights of persons with disabilities. This chapter dwells on the legal and institutional framework on the rights of women with disabilities with respect to their reproductive health rights. The legal aspect reviews the constitutional laws, other national laws such as the criminal and family laws, those national strategies, and policies. Additionally, those international laws and soft documents Ethiopia has signed and ratified will be scrutinized with their status of implementation at the national level. The compatibility of national laws to the international legal instruments will be examined. The next section of the chapter will examine the institutional framework that sector organization in the country such as the Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Women and Children Affairs, and Civil societies working in the area of Reproductive health and disability or both.

3.1. The Legal and Policy Framework on the Reproductive Health Rights of Women with Disabilities

There are a number of laws, policies and standards that Ethiopia has adopted pertaining to people with disabilities including their right to reproductive health right. The main ones are dealt adequately below.

3.1.1. Constitution of the Federal Democratic Republic of Ethiopia

The constitution asserts in its Article 25 the concept of equality of all persons before the law. It states that ‘all persons are equal before the law and are entitled without any discrimination to equal protection of the law. The equality protection renders guarantee of equal and effective protection to all person without discrimination on any ground of race, nation, nationality, or other social origin, color, sex, language, religion, political or other opinion, property, birth or other status. The ‘other status ‘listing includes disability and thus confirms the equality of WWD. The constitution equality provision also has some provision that do not conform to the non-discrimination principle with its international legal instrument counterparts enshrined under the bill of Right, CEDAW, CRPD, the African human right instruments like the protocol to the

African charter and the CRPD committee have observed that the inclusion of the concept ‘reasonable accommodation’ under Article 2 of the convention is not included in all areas other than issue related to employment and recommended for the adoption of a comprehensive definition of reasonable accommodation as one form of measure for discrimination.¹³¹ Maputo Protocol also reiterates the concept of positive measures by favoring women.¹³² Pre-empting arguments based on formal equality, the protocol requires states to adopt measures that may favor women above men in order to ensure substantive (‘in fact’) equality. This provision of the Constitution is critical for guaranteeing equal access to health by women and men.¹³³ The equality clause has also formed the basis for revisions of major laws that were previously discriminatory, such as family law and criminal law.¹³⁴ However, the efforts made to promote equality and combat various forms of discrimination against women often involve strategies and action plans that are not supported by a specific legal framework.¹³⁵ The legal framework coverage in the criminal law and the criminal justice policy is narrow and does not include all forms of discrimination. The criminal justice policy is not adequately enforced yet.¹³⁶

The Constitution showed a significant assurance to the protection of the women’s health when it stipulates the assurance of protection of women’s reproductive health under Article 35(9) which reads as

‘To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity.’

The listings of reproductive health are not exhaustive missing other reproductive health components such as the right to access reproductive health care and sexual education. These components however can be enlisted as in by incorporating international commitment through the appliance of Article 13(2) of the constitution. This article gives the freedom of interpreting fundamental rights and freedoms in conformity to the principles of the Universal Declaration of

¹³¹ CRPD Committee on the Right of Persons with Disabilities, Concluding Observation on Ethiopia on its Initial Report, 16th Session, 2016, par 9 and 10.

¹³² Maputo Protocol , Supra at note 48, Article 9(1).

¹³³ Mokedes F , Supra at note 35, pp 184.

¹³⁴ Ibid.

¹³⁵ CEDAW Committee Concluding Observation on the Report of Ethiopia on issues related to CEDAW, 72 Session, 2019, par 9.

¹³⁶ FDRE Criminal Justice Policy, 2011 available on <http://www.ethcriminalawnetwork.com/content/fdre-criminal-justice-policy-2011> accessed on May 12, 2019.

Human Rights, International Covenants on Human Rights and International instruments that are adopted by Ethiopia. The significant term ‘*Adoption*’ by the constitution here indicates that even non-ratified instruments that the constitution conforms with this instrument will be included. Adoption of an international instrument may indicate the time after negotiation, but prior to signature.¹³⁷ Article 9(4) however uses the word ‘*ratified*’ as opposed to the word ‘*adopted*’. Ratification under this article could mean that some national body analyses it and give its assent for the incorporation. Hence, to refer to international instruments only for the purpose of interpretation inter alia Article 13(2) not to become part of the law of the land, the international instrument shall not be ratified but adopted. The adoption criterion has an advantage in interpreting international instruments pertaining to the reproductive health rights. It entails that there is additional guarantee on WWD right beside the constitution by giving a channel to interpret all the rights and freedoms that have been adopted but not ratified and that provide the basis for interpreting the content of women’s right stated in the constitution. Article 13(2) also provides ample opportunity to draw inspiration from consensus documents such as the ICPD, the MDGs and regional soft laws concerning reproductive health of women.¹³⁸

Article 41(5) of the constitution sets out the state’s responsibilities in the provision of necessary rehabilitation and support services to ‘the physically and mentally disabled’. The wording of the article is out-dated and reflects a narrow, medical understanding of disability. The state is, therefore, obliged to ensure the rights of PWD as prescribed in the CRPD through the mechanism of interpretation. Proclamation No. 568/2008 on the Right to Employment for PWD is an applicable definition of Disability in Ethiopia. The definition in this proclamation reads: “Person with disability means an individual whose equal employment opportunity is reduced as a result of his physical, mental or sensory impairments in relation with social, economic and cultural discrimination.”¹³⁹ Even in this piece of legislation, we see that the term disability has not been clearly defined. Instead of directly addressing the term “disability”, the legislator seems to have decided to define a person with a disability.¹⁴⁰ The vague definition of disability in this

¹³⁷ The Amharic version of the Constitution, which is the governing language of the Constitution, clearly makes a distinction in the usage of the terms in Articles 9(4) and 13(2).

¹³⁸ Mokedes. F. Supra at note 35, pp166.

¹³⁹ Employment Rights of People with Disability Proclamation No. 568/2008, Art 2(1).

¹⁴⁰ Belayneh Admasu, Legal Protections Accorded to Persons with Disabilities under Ethiopian Law, Bahirdar University Journal of Law, Vol. 3 No 2, 2013, pp308.

proclamation by itself creates difficulty in understanding the concept, nature and type of disability of women.

The constitution complements the right to reproductive health in its provisions related to the right to marry and found a family,¹⁴¹ the right to be protected from harmful traditional practices and the right to enter into marriage with free and full consent and equal right.¹⁴² Article 35(9) of the constitution safeguards the right to family planning education and information. However, WWDs may have less access to family planning education and information, which is necessary for healthy and safe relationships, protection from HIV and other sexually transmitted infections (STIs), and realization of autonomy in family planning decisions.¹⁴³

Article 35(4) of the Constitution envisages that the State is obligated to enforce the right of women to eliminate the influences of harmful customs, law, and practices. Article 16 of the constitution ensures the protection of everyone from bodily harm. Female Genital Mutilation (FGM) defined by WHO, UNICEF and the United Nations Population Fund (UNFPA) as “the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other nontherapeutic reasons”¹⁴⁴. Cumulative reading of Art 16 and Art 35(4) of the constitution implies the provision of legislative measure of the constitution to eliminate FGM in line with its obligation of Maputo Protocol. The later identifies FGM as practices that negatively affect human rights of women.¹⁴⁵

Quality Reproductive Health care service includes the WWDs friendly and inclusive service provided with a reasonable accommodation in any of the public and private RHS sector. The state is under the obligation to train health care personnel with the notion of disability and their special need of treatment.¹⁴⁶ In this regard, concluding observation of CESCR committee identified the existence of poor health care service quality and recommends extensive training to health professionals in the field of reproductive health to decrease maternal and infant mortality.¹⁴⁷

141 FDRE Constitution, Article 35(1).

142 Ibid, Article 35(2).

143 Meaza Yirga et al, Assessment of family planning need of Women with disabilities, USAID & Ministry of Health, 2017 pp6.

144 Progress in Sexual and Reproductive Health Research, FGM- New Knowledge Spurs Optimism, No 72, WHO. available at https://www.who.int/reproductivehealth/topics/fgm/progress72_fgm.pdf accessed on May 24, 2019.

145 Maputo Protocol , Supra at note 48, Article 5.

146 CESCR Committee, Concluding Observation on Ethiopia, 48th Session, 2012, par 25.

147 CEDAW Committee Concluding Observation, supra at note 135, Par 37(e) and 38(d).

3.1.2 The 2005 Criminal Code and the Revised Family Code

Criminal law is crucial to protect women's right to reproductive health. It promotes the health of women by punishing rape, domestic violence, and harmful traditional practices. Criminal Code criminalizes circumcision and infibulation of female reproductive organ. The state is under the obligation to prevent FGM because it has the duty to prevent further disability by providing prevention mechanisms.¹⁴⁸ FGM is punishable by law depending on the severity of the circumcision from 3 to 5 years.¹⁴⁹ The law enforcement report of UNICEF's Annual report in 2012 illustrates the existence of criminal prosecution of the perpetrators. In 2012, in the Afar region, a traditional FGM performer and the parents of six girls were arrested, tried and sentenced. The performer received a six-month prison sentence and the parents were fined 500 Birr (US\$ 27) each.¹⁵⁰ Although the law may bring perpetrators to court, in practice, the guilty often receive pardon.¹⁵¹ In case where the perpetrator is criminalized, the penalty is regarded as 'a slap on the wrist'¹⁵² since the consequence on the reproductive health, if not on the life, of the WWD is irreversible to the severity of penalty received by the perpetrators. Albeit the degree of the penalty to the action, the government opts to resort to public awareness creation mechanism, as the deterrence effect is also compromised because of the challenges the law enforcement encounter to bring the criminal to justice.¹⁵³ These challenges are the results from the nature of the act (FGM) that it is being done in the private sphere and the victims are mostly children who cannot speak for themselves.¹⁵⁴

The Code addresses violence against women or gender based violence (GBV) in different forms: by expanding the existing vague provision, by introducing new offences, by redefining the elements of these offences, by adding aggravating circumstances and by revising the penalties

¹⁴⁸ CRPD, supra note at 20, Art 25(C).

¹⁴⁹ The Revised Criminal Code 2005, Article 587 and cumulative reading of Articles 565 and 566.

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² OLINDA BAREIRO-BOBADILLA, expert member from Paraguay, speaking in the report examination of CEDAW Forty-ninth session, July 2011 available at https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/E_CN-6_2012_CRP-1%20_21047_E.pdf accessed on May 26, 2019.

¹⁵³ Maputo Protocol, supra at note 48, Article 5(a).

¹⁵⁴ However in Woliyta, Goffa, Arsinegle FGM is conducted just before marriage or on the betrothal and in Goffa, Sidama just before the consummation on the average age of ten year or plus.

applicable in cases of violation.¹⁵⁵ Consequently, the code criminalizes most forms of violence against women and girls including rape,¹⁵⁶ trafficking women,¹⁵⁷ prostitution of another for gain,¹⁵⁸ and physical violence within marriage or in an irregular union,¹⁵⁹ abduction,¹⁶⁰ Female Genital Mutilation¹⁶¹ and early marriage.¹⁶²

Gender based violence such as rape infringes WWD's right to the enjoyment of sexual liberty as this is one element of the reproductive health right. The criminal law under its provision 620-628 proscribes the action and put forth its penalty. WWD are mostly vulnerable to rape as a result of their limited mobility, especially for woman with physical and sensory impairment.

Safe abortion is another fundamental RHR that WWD is denied. The 2005 criminal code expanded abortion law of the country where by it is legality stretches to a case of rape , incest , or fetal impairment or if it endangers the life of a woman or if the woman has a physical or mental disabilities or is a minor who is physically or mentally unprepared for child birth. The 2006 national standard and guideline also included the use of medical abortion to terminate pregnancy. ¹⁶³A woman's declaration is sufficient to prove the existence of these exceptional circumstances.

3.2. Institutional frameworks on the Right to Reproductive Health Right of WWD

3.2.1. Governmental-Stakeholders

Disability is a cross-cutting issue requiring a multi-sectoral response in the formulation of disability inclusive strategies, action plans and implementation. The Ministry of Social and Labour Affairs (MoLSA) is the leading Federal ministry for the advancement of rights of persons with disabilities in almost all matters. Within the ministry, the Department of Rehabilitation

¹⁵⁵Megersa Dugasa, The Ethiopia's Legal Framework on Domestic Violence against Women: a Critical Perspective, International Journal of Gender and Women's Studies, American Research Institute for Policy Development 2014, Vol. 2, No. 1, pp49-60.

¹⁵⁶ The Criminal Code, 2004, supra at note 148, Articles 620-28.

¹⁵⁷Ibid, article 597.

¹⁵⁸ Ibid, article 634.

¹⁵⁹ Ibid, article 564.

¹⁶⁰ Ibid, articles 587-590.

¹⁶¹ Ibid, articles 565-6.

¹⁶² Ibid, article 649.

¹⁶³National Standards and Guidelines for safe abortion in Ethiopia. 2006 available at http://phe-ethiopia.org/resadmin/uploads/attachment-161-safe_abortion_guideline_English_printed_version.pdf accessed May 29, 2019.

Affairs has the mandate to coordinate disability issues at the federal level, provide policy guidance and technical support to other organs of state. There are 11 bureaus of labor and social affairs that implement the national plan of action and promote the integration of persons with disabilities at the regional level. All other ministries are required to mainstream disability issues in their respective areas of technical competence. However for the purpose of this research policies and strategies from Federal Ministry of Health, Federal Ministry of Women and Children Affairs are consulted. The Ministry of Health (FMOH) is responsible to provide general health services to persons with disabilities along with the rest of the population, and there is a Reproductive and Maternal health department that has focused little on WWDs.

The FDRE Ministry of Social and Labour Affairs (MOLSA) is also in charge of dealing with rights of women, however there is no direct responsible for disability issues. As Per the proclamation other ministries are also required to take responsibility for mainstreaming disability into their respective areas of work. Policy provisions in the NPA of inclusion of PWD hold its objective to increase awareness and information about disability among society. The provision of appropriate training of health care personnel in public & private health facilities in the delivery of inclusive family planning and reproductive health services to women and girls with disabilities. Policy provisions in the NPA of inclusion of PWD hold its objective to increase awareness and information about disability among society. The provision of appropriate training of health care personnel in public & private health facilities in the delivery of inclusive family planning and reproductive health services to women and girls with disabilities¹⁶⁴ However, the actual implementation is short of any monitoring of such applications by the ministry. The ministry is under the establishment of a new department that deals with Disability issues independently, and the women and a child affairs department has more or less no focus on women with disabilities in particular.¹⁶⁵ The new department is under establishment focuses mainly on PWD and older. It is engaged to promote the rights of PWD in general. The Ministry also lacks a disability Act which is a prominent in the realization of rights related to WWD. Ministry believes that the NPA, the national laws and all ratified UN convention and other documents are sufficient to entertain the rights of PWD rather than promulgating a separate Disability Act.¹⁶⁶ The FDRE

¹⁶⁴ National Plan of Action on inclusion of persons with disabilities, 2012-2021, MOLSA, 2012, para 2.16 pp 22

¹⁶⁵ KI7, Mrs. Meaza Wolde , Women and children directorate director, interview conducted May 21, 2019

¹⁶⁶ KI8, Mr Merid Mengesha, Team leader, Rehabilitation and Services Promotion, MOLSA, interview conducted May 21, 2019.

Ministry of Women and Children also is a ministry that works on the rights of women in the federal level. The Ministry has no particular section for the issues or right to women in disabilities¹⁶⁷. The ministry has started monitoring the inclusion and mainstreaming of women issues in each program and strategic document of other ministers. The ministry to this effect has an oblique reference to WWD and their RHR in its document, Ethiopian women development and transformation strategy and package.¹⁶⁸ These documents only remark the inclusion of WWD in the general legal frame work such as revision of the law, monitoring enforcement mechanisms and assuring the protection and inclusion of women. Specific issues include related to RHR include pre and post natal services available and accessible, the training of health care personnel in public & private health facilities at all levels.¹⁶⁹ Financing and budgeting of health system is state obligation in most international instruments including the Maputo Protocol¹⁷⁰.

3.2.2. National Statutory bodies

The principles relating to the Status of National Institutions (The Paris Principles)¹⁷¹ state that a national institution should be vested with competence to promote and protect human rights, and that the mandate should be as broad as possible. The two most prominent institutions are the human rights commission and the ombudsman. The role of Ethiopian national human rights institutions is secondary to the executive, legislative and judicial organs of the government. The prominence of these institutions in the protection of RHR of WWD in particular is insubstantial.

3.2.2.1. The National Human Rights Commission

The mandate of the commission stretches nationally with 8 of its regional branches and its application is broad to include all violation of any human right.¹⁷² Human rights in this context are defined as those stated in the Constitution as well as those enshrined in international treaties

¹⁶⁷KI9, Mr Seleshi Tadesse, Director, Women mobilization and participation enhancement Directorate, Ministry of Women and Children, Interview conducted May 22, 2019.

¹⁶⁸ Ethiopian Women development and change strategy, and Ethiopian Women development and change package , Ministry of Women and children, 2017 paragraph 2.5.4 and 3.3 respectively.

¹⁶⁹ Ibid.

¹⁷⁰ Maputo Protocol, supra at note 48, Article 26(b).

¹⁷¹ Principles Relating to the Status of National Institutions (The Paris Principles) Adopted by General Assembly Resolution 48/134 of 20 December 1993

¹⁷² Proclamation to Provide for the Establishment of the Human Rights Commission Proclamation 210/2000, 2000 Article 5.

ratified by Ethiopia.¹⁷³ Therefore the RHR as a human right are included in the definition and all international treaties ratified by Ethiopia are instruments to protect WWD. The prominence of these institutions in the protection of RHR of WWD in particular is insubstantial. The Commission has a Special Commissioner which follows the general mandate for equality in human rights commission project but specializes in the rights of children, women, and people with disabilities. The commission has currently opened legal aid centers in collaboration with universities and civil societies. The special commissioner's activities are more limited to education rather than protection or monitoring of violence to RHR of women. The knowledge and conception of the experts over the issues of WWD and reproductive health is inadequate. Accordingly this calls for actualization of the CEDAW committee recommendation over strengthening the capacity and independence of the Ethiopian Human Rights Commission, especially the Commissioner for Women's and Children's Rights and the department.¹⁷⁴ The committee again recommended Ethiopia to provide the commission with sufficient, technical and financial resources to carry out its mandate.¹⁷⁵

3.2.2.2. The Ethiopian Institution of the Ombudsman (EIO)

The Ethiopian Institution of the Ombudsman (EIO) as one of human right institutions in the country works with an objective stated as '...to see to bringing about good governance that is of high quality, efficient and transparent, as based on the rule of law, by way of ensuring the citizens' rights and benefits, provided for by law are respected by organs of the executive'¹⁷⁶EIO has a directorate that deal with the issue of women, children and disabilities by ensuring the executive for any maladministration. However the EIO has no direct complaint mechanism neither receive any remedy for individual complaints. Information regarding the work of the EIO is non-existent, including cases addressing maladministration committed against interests of women.¹⁷⁷Therefore it is plausible to say that the organ has never entertained any RHR pertaining to any person.

¹⁷³ Ibid, Art 4(1).

¹⁷⁴ CEDAW Committee Concluding Observation on the report of Ethiopia on issues related to CEDAW, 49th session, 2011, Paragraph 17(d)

¹⁷⁵ CEDAW Committee Concluding Observation , Supra at note 135, par 18.

¹⁷⁶ Proclamation to Provide for the Establishment of the Human Rights Commission Proclamation 211/2000, Article 5. The proclamation is currently submitted for its revision to strengthen its work.

¹⁷⁷Mekedes F., supra at note 35, pp172.

3.2.3. Non-state Actors

The role of international or local non-governmental organizations (NGO), community based organizations (CBO) and Disability associations (DPO) in the realization of RHR of WWD is remarkable. The realization of RHR is progressive and need adequate resources for the fulfillment of state's obligation. The state therefore should provide a legal framework that is conducive to the activities of non-state actors. The extent to which a State allows other actors to operate in health matters serves as an indicator for implementation performance.¹⁷⁸ The CRPD committee has also recommended that the state should ensure the involvement and consultation of organizations working on WWD.¹⁷⁹ Activities of non-state actors in Ethiopia are monitored by the civil society organization the then Charities and Societies Agency which prohibits advocacy of human rights issues.¹⁸⁰ The charities and societies proclamation is now amended and subsequently replaced by a new proclamation no 1113/2019. The past law has curtailed many non-governmental organizations to involve in the advocacy works in the reproductive health education, information and lobbying of RHR. The CEDAW committee appreciating the promulgation of the new proclamation mentioned its concern on the limitation of the scope of activities of INGOs and the existence of administrative obstacle.¹⁸¹ Hence, it recommended that Ethiopia should ensure the CSO including women human right defenders and activities are able to freely carryout their work of protecting women's human rights.¹⁸²

3.3. Realizing Reproductive Health Rights of WWD

There are many barriers that hinder the guarantee of WWD to any of RHR enshrined under any of the national laws. Ensuring that WWD can successfully access the RH services, information and education as a right, requires identifying and attending barriers that hampers its realization. In order to get ample data the researcher conducted 2 FGDs in 2 organizations (ENAD and EWDNA).¹⁸³ Each focus group had 14 and 27 participants respectively. Population of the data

¹⁷⁸ Ibid.

¹⁷⁹ CRPD Committee concluding Observation, supra at note 131, par 14.

¹⁸⁰ Charities and Societies Proclamation No 1113/2019.

¹⁸¹ CEDAW Concluding observation, supra at note 135, par 29.

¹⁸² Ibid, par 30.

¹⁸³ These organizations were selected because the participants are member to both organizations and EWDNA would have women with different disabilities. Women from ENAD were also members of the association within a different reproductive age group starting from 19 to 42 years of age.

was selected based i) Sensory and physical disability; where mainly woman with vision, hearing, and speech or both and physical impairment ii) WWD in the reproductive age group , hence the minimum age was 19 and the maximum 42; iii) women should be from a different walks of life in their education , martial and economic status. Each FGD took approximately two hours with an interpreter to flawlessly communicate. The purpose of conducting the FGD is to learn the lived experience of WWD and appraise the level of awareness of their rights pertaining to RH.

Key informant interview were held with 11(Eleven) personnel from Civil society and government organizations. These are mainly representing EWNAD, FGA, ENAD, Addis Ababa Public Prosecutor office, EHRC, MoH, MoWCA, MoLSA,. The organizations are selected based on their relevance and closeness to the issue of Reproductive health and WWD. The purpose of holding a key informants interview was as to obtain a special knowledge from them.¹⁸⁴ Each interview took 20 to 45 minutes depending on the issue raised. Major areas of concern and questions asked relate to access to RHR such as information dissemination or awareness creation, scrutiny of the level of the right protected, promoted and respected, how laws, policies and strategies are implemented or enforced by state actors and non –state actors.

The FGD discussion and key informant data reveal limited or zero awareness of their rights by WWDs and its impact in demanding it; challenges on enforcement and actual practice to realize these rights; the adverse effect on the violation of RHR on WWD and constraints that limit the materialization of this rights in the through policies and strategies.

3.3.1. Barriers to reproductive health rights in Ethiopia, a case study in Addis Ababa

The research found out barriers that limit the realization of WWD to the fullest enjoyment of these rights emanates from the *Reproductive health care delivery* and *Justiciability and legal protection of RHR*.

¹⁸⁴Zuker , D.M , How to do a Case study research, AAU, School of Nursing Publication series Vol. 2 available at http://scholarworks.umass.edu/nursing_faculty_pubs/2; accessed on June 1, 2019.

3.3.1.1. Barriers on Reproductive Healthcare Delivery

For the purpose of this paper barriers on health care delivery or on access to reproductive health care service, information and sexual education are categorized the demand side or the women themselves and external healthcare providers such as health infrastructures and personnel.

A. WWD or Demand Element

This barrier category mainly focuses on knowledge, economic status, disability type and self-awareness of WWD and their lack of information on the availability of reproductive health care service, information and sexual education. Available research suggests that people with disabilities are often unaware that they can access healthcare services in the mainstream health centers.¹⁸⁵ KI1 explains that low literacy rate in the deaf community hinders their access to RH information through printed materials or electronic medias such as the internet. This is also true in the visually impaired community. It was found out from FGD participant that most women with sensory impairment end up in unwanted pregnancy as a result of lack of information that performs safe abortion. It was reported in the FGD among deaf people awareness on family planning services and methods, the knowledge regarding the types and importance of each family planning method and sources of family planning services found to be low. To this end, communication barriers, limited access to family planning service information, unavailability of sign language interpreters in health facilities, and media based dissemination of information non-tailored to deaf people accounted for low knowledge of family planning services. In a key informant interview Tigist explains,¹⁸⁶

“There is a limited awareness on the types of family planning methods and their use, there is a big gap because information dissemination in TV are not accessible to the deaf because they didn’t use sign language interpretation. Some deaf don’t know how to prevent pregnancies and how to get safe abortion services for unwanted pregnancies. They don’t have access to this type of important information”.

¹⁸⁵ Barrier to Healthcare services for people with Disabilities in Developing countries ; Literature review, light for the world , 2017, pp 6 available on <https://lab.light-for-the-world.org/wp-content/uploads/2018/01/Literature-review-barriers-health-care-20-07-2017.pdf> , accessed on May 24, 2019.

¹⁸⁶ KI1 , Tigist Nadew, An intern at the ENAD, conducted on May 7, 2019.

Furthermore there is limited awareness on the various family planning methods among women with hearing impairment.

“Previously, deaf people were not using family planning methods but now a day many deaf are using family planning methods. There are also many deaf who don’t know about family planning methods. They still have sex without taking care. They don’t go health centres for counselling because their awareness is very low.” Single deaf woman

- ✚ WWD are mostly poor as a result of lack of employment opportunity. Economic independency of WWD to receiving RHS and additional expenses related to RHS are major obstacle. Berhane explains,

‘Once I went to a health centre for a check-up after a miscarriage, the doctor told me to have an ultrasound. I didn’t have any money even for transport let alone for an ultrasound examination. Fortunately my cousin gave me the money and was able to have the service’.

- ✚ Limited mobility of women with physical and visual impairment in accessing RHS in many ways. Their mobility may be restricted on dependability of an accompany family or friend which infringes their right to privacy. Unfriendly and inaccessible infrastructure such as poor roadways, sidewalks and non-existence of ramps typically restrict their access to any kind of reproductive health services. Most participants agree that they would rather not know their HIV status or pregnancy than to ask for accompany to a health center.
- ✚ Effects of Stigmatization and marginalization of the community or family on WWD are the notable factors to RHS. Negative attitude influences confidence and generate feeling of rejection and shyness among WWD in their reproductive healthcare seeking behaviour. KI₃ describes that deaf women do not attend the health center or ask questions for fear of appearing ignorant about their own health conditions. They also do not utilize reproductivehealth services when needed because they felt ashamed for not being able to ask simple questions.¹⁸⁷

¹⁸⁷ KI₃ , Selamawit Tessema, social worker at EWDNA, conducted on May 9, 2019.

B. Reproductive health care (suppliers Element)

There is generally low level of quality reproductive healthcare service to WWDs rendered by health professionals that compromises and hampers the accessibility of RHS.

- ✚ Health care staff and service provider's attitude towards the sexuality of WWD and their subsequent reproductive health care services is the prominent barrier to WWD. The negative attitude may result from healthcare staff and service providers insensitivity either purposely or due to lack of knowledge towards the special need of WWDs in the area of RHS.¹⁸⁸ Participant of the FGD, Yemiserach, a physically impaired women as a result of early polio infection using both crutch for mobility testify this situation as

‘ When I first knew that I am pregnant and needed to start a prenatal follow up for my first pregnancy the nurse got confused and ask me again if the service was for me . Normally the nurse would take the vital sign for any woman but she called other nurses to confirm my request. I can hear her gossiping behind my back before she proceeds with the service.’

Most participants agree that they get ridiculed verbally, physically, mentally by health professionals when they requested for HIV or pregnancy test. All participants who had gone through delivery complained that they were physically restrained during labor. This is typically against their right to bodily integrity. Use of derogative words like ‘*komata*’ ‘*Ewere*’ and ‘*Denkoro*’ which is the violation of her right to be free from inhumane and degrading treatment as proscribed under the criminal law Article .

- ✚ Communication barrier is the primary challenge for WWD to RHS. Almost all public or private hospitals and health centres in Ethiopia either understand nor appropriately communicate in sign language, nor are sign language interpreters available to interpret except St Paul Hospital Millennium Medical College and Zewditu Memorial Hospital have no sign language interpreter at all for communication¹⁸⁹. In an interview with KI₃, there are few deaf people who have lost their babies because of misunderstanding the instruction of midwives or a deaf woman reported having received just paracetamol for a

¹⁸⁸ Ibid Supra at note 135, pp6

¹⁸⁹ KI₁ Supra at note 134

very complicated situation of her pregnancy.¹⁹⁰ Indirect communication, such as brochures are challenges to people with visual impairments because they are unable to comprehend information embedded in pictures or on flip messages given on the radio, likewise, are inaccessible for people with hearing impairments. Berhane a woman with visual impairment in the FGD explains the difficulty that woman of her kind experience in accessing contraceptive pills because they could not follow the direction to use every day.

- ✚ Inaccessible Health facilities and equipment are major limitation to WWD to access reproductive healthcare mostly for women with physical or visual impairment. The nonexistence of ramps, inaccessible latrine or toilet is the biggest problem. Miserak who is a physically impaired women in a FGD states the issue as

‘Mostly we (the physically impaired women) do not go to toilet for any stool examination if we are alone. There are many times I tried to use the toilet to give a stool sample but failed with my back on the floor. In addition when I had all three of my children I had a difficulty to sit on the delivery couch because it is not adjustable’.

The Concluding observation of the committee on CEDAW mention its concern on WWDs their difficulty in gaining access to RHS and that the health care system often does not provide such services and cannot ensure reasonable accommodation for WWD. The committee recommends Ethiopia to ensure that all women and girls with disabilities have access to health services including sexual and reproductive health services, and are provided with reasonable accommodation.¹⁹¹

3.3.1.2. *Justifiability and Legal Protection of Reproductive Health Rights*

Justiciability is the extent to which an alleged violation of subjective socio-economic right invoked in a particular case is suitable for judicial or quasi-judicial review at the domestic level.¹⁹² There are three normative preconditions in the above assertion namely, the existence a legally protected right that is endangered or violated (claim element); the existence of a judiciary or quasi judiciary to adjudicate the socio- economic right within the jurisdiction (the setting

¹⁹⁰ Interview conducted with Mrs Amsale Fufa , Inclusive Health Project Coordinator, ECCD , conducted May10, 2019

¹⁹¹ CEDAW Committee Concluding Observation on Ethiopia, Supra at note 135, par 37(e) and 38(d).

¹⁹² Amare Tesfaye, Justifiability of Socio Economic Rights in Federal Democratic Republic of Ethiopia, 2010 pp 76

element); and the availability of remedy (the consequence) .The cumulative existence of these normative preconditions in the Ethiopian legal system panoplies the direct or indirect justifiability of socio economic right. While the direct way would be grounded on the provisions of substantive part of the Constitution and ratified treaties because of the cumulative fulfillment of the three-pronged test of Justiciability in both legal frameworks, the indirect way would be grounded on the provisions found in the NPPO due to the absence of one of the cumulative requirements for the direct justiciability of socio-economic rights (the claim element of justiciability).¹⁹³

What does the justiciability of socio economic rights entail for the protection of RHR for women with disabilities? WWD as a marginalized section of the society will be able to reclaim equality in the area of access to reproductive health care service, goods and information ; creates understanding of RHR rights as a legal right among legal and medical professionals, have the benefit of ensuring accountability, transparency, and responsibility from the government, alleviating the gratuitous abuses of these rights, combating the perpetuation of gender based violence , develops trust on the judiciary for adequate remedy , and maintaining the sovereignty of the State in the adjudication of cases.

The justiciability jurisprudence of socio economic right in Ethiopia is under developed despite the normative possibility as discussed above. In an interview conducted with a public prosecutor on the existence any claim on the base of RHR violation, he stated that

‘I have never encountered any women who sought a remedy for the violation of her right to have family planning service in which she ended up with unwanted pregnancy and could not again have a safe abortion as a result of inaccessibility of a health centre’s staircase, bed or toilet that infringes her’¹⁹⁴

He also mentioned that

‘ Even if there is a jurisprudence on any other violation of their right that entrench to the civil rights such as the right to life in the case of rape or FGM there are different barriers to access justice for WWDs such as the level of awareness to on their right perse or economic capacity ‘¹⁹⁵

¹⁹³ Ibid, pp117.

¹⁹⁴ KI10, Tekalegne Duge, Addis Ababa Public Prosecutor Office, Public Prosecutor interview conducted on May 26, 2019.

¹⁹⁵ Ibid.

This remark asks for the existence of barriers to access justice by WWDs. The following subsection deliberates this issue.

3.3.2. Ensuring Access to Justice for WWD and Overcoming Barriers

WWDs face multiple barriers to access to justice and seek adequate remedies for the violation of RHRs. The CEDAW committee observed that WWD lack access to justice (as one of the multiple form of discrimination) and the state should guarantee appropriate access to justice¹⁹⁶. The justifiability of RHR as an Economic, Social and Cultural right undermines these right to entertain, interpreter and enforce them in one hand and access to justice by WWD is the other impeding factor.

Below are pinpoints on essential barriers to access justice by WWD

- ✚ Lack of awareness of their right, that they have equal right with enabled women, where the WWD have especially deaf women have no conception on where to go to claim there right. KI₆ explains that deaf women come to the association in search of justice because they have no idea how to sue the person who violated their right either in marriage disagreement, child alimony, rape or any domestic violence. ¹⁹⁷ the state is under obligation to ensure that¹⁹⁸
- ✚ Distrust over the law enforcement, limited knowledge of the justice or court staff, lawyers and police men or prosecutors on investigation of case related to WWDs. Unavailability of adequate procedural accommodation during the hearing process of violations.¹⁹⁹ The CRPD committee recommends that Ethiopia should ensure compulsory and regular training for justice and Police staff on the rights of PWD. The state is also required to avail effective procedural accommodation at all stages of investigation and court proceedings to PWD²⁰⁰

¹⁹⁶ CEDAW Committee Concluding observation, supra note at note 135, par 50(d).

¹⁹⁷ Rahel Gesses, Record officer at ENAD, interview conducted on May13, 2019.

¹⁹⁸ CEDAW Committee Concluding Observation, supra at note 135, par 1(C).

¹⁹⁹ Ibid, par 36(C), CRPD Committee, Concluding Observation Supra at note 127, par 29.

²⁰⁰ Ibid , paragraph 30

- ✚ Insufficient substantiation of claim to furnish evidence such as the case of visually impaired women to identify her rape perpetrator. This again seeks availability of effective procedural accommodation.²⁰¹
- ✚ Inaccessible infrastructure of the police station, absence of interpreters in the law enforcement offices. The communication barrier between the law enforcement body and WWD compromises the quality and message of the communication. The CERPD Committee recommends that the State party take all legislative and other measures to significantly increase the number of trained and qualified sign language interpreters throughout the territory and to recognize and promote the use of sign language as an official language.²⁰²
- ✚ Lack of economic resources can directly impact WWD to access to justice in numerous ways. For example it can affect one's ability to engage and pay for quality legal counsel where it is not provided at no cost; to engage in litigation, which can be expensive and lengthy. Therefore, in seeking to overcome economic obstacles the critical role of legal aid should be considered. Ethiopia is under the obligation to ensure that effective access by women to judicial and legal services including legal aid.²⁰³The federal attorney general has a duty to represent victims of crime who do not have financial means in litigations or negotiations for their compensation, reinstatement and protection of their civil interests emanated from the damage sustained.²⁰⁴ The typical legal aid involves pro bono obligations imposed on licensed lawyers²⁰⁵. The pro bono service by practicing lawyers, legal aid services, legal literacy and public interested litigation by law school legal aid centers and civil society organizations are some of the strategies to ensure accesses to justices. ²⁰⁶

²⁰¹ CEDAW committee Concluding Observation, supra at note 135 par 24(e) even if the recommendation is for women in general the applicability of it to WWD will further advance their right.

²⁰² CRPD Committee Concluding Observation, supra at note 131, par 47 & 48.

²⁰³ Maputo Protocol, supra at note 48, Article 8(a).

²⁰⁴ Federal Attorney General Establishment Proclamation No. 943/2016.

²⁰⁵ Federal Courts Advocates Licensing and Registration Proclamation No. 199/2000.

²⁰⁶ Mizane Abate, et al, Advancing Access to Justice for the Poor and Vulnerable through Legal Clinics in Ethiopia, Mizan Law Review Vol. 11, No 1, 2017, pp2.

Conclusion

This chapter starts with the legal and policy frameworks that Ethiopia has to protect and realize the RHR of WWD. The chapter first consults the national laws such as the constitution, criminal and Family laws. The constitution Article 25 states equality before the law and entitlement to equal protection without any discrimination of the law and it lists out ‘Other Status’ as a ground for non-discrimination. This ‘other status’ listing includes inter alia Disability. The constitution even though ample in assuring guarantee for non-discrimination entitlements, it did not provide measures of ‘reasonable accommodation’ as to disability in line with Article 2 of CRPD. The only measure of reasonable accommodation is mentioned employment proclamation. In addition the constitution is narrow in its understanding of disability as a medical approach. However by interpretation mechanism of Art 13(2) and 9(4) of the constitution the thesis bases its understanding of disability as stated on CRPD. Article 35(9) guarantees the right to RHR which deals only one component of RHR and lacks the right to RH services and RH education right to the constitution equality provision forms a basis for the formation of the criminal law and family law which deal with the issue of RHR. Pertinent provisions relevant to the thesis are enshrined under art 620- 628 , which deals with GBV , FGM and rape that exacerbate and furthers the disability or impairment of WWD. The code redefined and proscribe this criminal actions and put forth penalty. The code also expanded abortion law and hence creat opportunity for safe abortion for WWDs.

Institutional guarantee of the right to health was the second section of the chapter . Institutions were classified as governmental sectors and statutory organizations. The governmental sectors that are imperative in their policy towards the protection and promotion of RHR of WWDs include the MoH, MoWCA and MoLSA. These ministries have policies that aspire for the inclusion of women in many sectoral services of the government activities. The MoH has a national strategy plan for the year 2016-2020 that deal with RHR, however the budget and financing for RHR are not disaggregated by disability status for the identification of its emphasis on WWD. The MoWCA, has a women development and change strategy and package which ensures the advancement of women right in general . There is almost no focus on these documents regarding RHR of WWD the realization of RHR and the protection of WWDs. The statutory organizations of the government such as the EHRC and the Omdurman (EIO) have no

substantial involvement in the monitoring of socio economic rights except educational approach for the protection. The commission currently operates in a legal aid activity in collaboration with Universities and CSOs. The EIO has no direct individual complaint mechanism therefore the redress or remedy for RHR violations will not be entertained directly. The non -state actors that are relevant for the promotion and realization of RHR are the CSO. Ethiopia has amended its crippling proclamation of charities and societies with Proclamation 1082/2019. The new proclamation allows CSO to engage in advocacy of Human rights and thus it is a great opportunity for CSO and association to get direct fund for the advocacy of RHR of WWD in particular. The institutional framework section also scrutinizes and tries to include concluding observation of CEDAW, CRPD and ICESCR committee and incorporate each recommendation in thematic area of observation.

The last section of the chapter deals with realizing RHR of women with disabilities. Therefore in order to identify and ensure the realization of these rights the researcher tries to identify barriers that hamper the effective protection, promotion and realization of RHR to women in Addis Ababa. To this end a case study of women with sensory and physical impairment was conducted. 2 FGD and key informant interview was held regarding knowledge, access and violation of RH services, information and education. Access to legal service and its justiciability were also addressed in this section.

The healthcare barriers relate to the demand side and the healthcare provision. It was identified that lack of awareness, information, economic dependency, mobility difficulties, self-pity and confidence are some of the barrier. The healthcare provision barrier narrated include poor health staff attitude and awareness towards the sexuality of WWD and their demand for RH care provision, poor healthcare service delivery, inaccessible infrastructure and medical equipment , communication barrier . The right of WWD to RHR can only be respected and protected when the judiciary is accessible. The issue of justiciability of RHR like other SER requires the cumulative existence of 3 normative pre conditions namely the claim, setting and consequence element. RHR as justiciable right to WWD means they can reclaim equality free of any discrimination, ensure accountability and transparency of the state, combat perpetrators in case of violation and trust the judiciary for any redress or remedy. However WWD encounter barriers to realize their right. The barriers to access justice for WWD are also aligned into factors from the right bearer (WWD) and duty bearers (legal enforcement bodies). Lack of awareness to their

right *per se*, fear of stigma and isolation, distrust over the law enforcement unavailable or inadequate procedural accommodation, insubstantial claim to furnish evidence, inaccessible infrastructure and communication barriers, economic incapacity to procure legal representation and consultation are factors that curtail to effectively access and realize RHR for WWD. The existence of legal aid centers and legal clinics in universities, the legal requirement for pro bono works of lawyers and the advocacy work by CSO and DPOs will alleviate the problem by considerably.

Chapter Four

4. Conclusion and recommendation

4.1 Conclusion

The CRPD recognizes the need for the promotion and protection of human rights of PWDs in civil, cultural, economic, political and social life, with the appropriate measures of implementation. Hence for the protection and promotion of the human right of WWDs require a clear identification of individuals that deserve the protections and the extent to which these protections are agreed at different human rights instruments. Article 6 of the Convention recognizes that WWD face multiple and intersecting forms of discrimination. Disability inclusion and gender equality cannot be achieved without addressing WWD's SRHR. Sexual and reproductive health and rights are human rights. They are not only an integral part of the right to health, but are necessary for the enjoyment of many other human rights, including the rights to life, freedom from torture and ill-treatment, freedom from discrimination, equal recognition before the law, privacy and respect for family life, education and work. As such, SRHR are universal and inalienable, indivisible, interdependent and interrelated. SRHR encompass both a set of freedoms and entitlements such as the right to have control over decisions concerning sexuality and reproduction without discrimination, coercion and violence, and the right to access a range of sexual and reproductive health facilities, services, goods and information.

The study raises three questions; these are the international legal frame work on the protection of RHR, the state obligation towards guaranteeing these rights; the legal and institutional frame works encompassing RHR and; the constraints at normative and institutional level to access Reproductive health care and rights with the identification of barriers to access justice. These issues are addressed in their order based on primary and secondary data. Focus group discussion and key informant interview were conducted to probe the relevant information to answer the research questions. Based on this, the following conclusions are drawn.

International instruments deal with the RHR in their scattered articles. The ICPD shift to right based approach of RH imbues the right a legal protection and ethical consideration. ICESR in Article 12 and its General comment 22 confirm that the substantive element of the RHR

incorporate human rights individual decision and autonomy. Cumulative reading of Article 8, 18 and 21 stipulates that the protection of these rights guarantee the protection of RHR. The CEDAW in its Article 16 on the guarantee of health related rights including decision on the number and spacing of children. Article 12 formulates an obligation to eliminate discrimination on the provision of healthcare including family planning. General recommendation 18 of CEDAW makes a specific concern of reproductive health of women. Maputo Protocol stretches an undeniable normative step forward by making substantive rights of women unequivocally binding. Therefore states must ensure the normative contents of the right; the (AAAQ) availability, accessibility, acceptability and quality of facilities, goods, information and services and the obligation to guarantee equality and non-discrimination related to SRHR.

The four interrelated freedoms of RHR include 1) the right to equality and non-discrimination; (2) the right to marry and found a family; (3) the right to reproductive health, including family planning and maternal health services, information, and education; and (4) the right to be free from Gender based violence.

The obligation of states on RHR as the right to health is progressive however there are 7 core obligations for the materialization of RHR. These are Elimination of discriminatory laws, guaranteeing access to quality reproductive health services, legal prohibition of GBV and HTP, ensure measures to safe abortion, ensure comprehensive sexual education, provide essential medicine and medical equipment, ensure access to effective remedies & redress upon violation.

Ethiopia has a good record of ratifying international and regional binding instruments. Recently Ethiopia has ratified the Maputo protocol. Ratification of these core instruments entails the obligation to respect, protect and fulfill the right enunciated therein through the measures of implementation. Hence the research concluded that Ethiopia has made a milestone in the ratification and there by domestication of pertinent instruments related to RHR.

The national legal and institutional framework addresses the issue of RHR of WWD in scattered legal and policy frameworks related under the right to women, right to health or the right of persons with disabilities in general. The constitution has a legal lacuna in addressing the meaning of persons with disabilities in that the wording of the article is out-dated and reflects a narrow, medical understanding of disability. Disability has not been defined by any of the national laws.

The employment proclamation is the applicable description for persons with disabilities in Ethiopia. The constitution also generically set other status for the ground of non-discrimination before the law and equal protection of the law. Thus disability ground for non-discrimination is not listed clearly. The listing of reproductive health care in Article 35(9) omits other reproductive health components such as the right to access quality reproductive health care (pre and post maternal health care), comprehensive sexual education and, safe abortion, the right to be protected from Sexual transmitted infections and HIV AIDS. The constitution did not set a reasonable accommodation obligation to ensure equality and non-discrimination among WWD in the health aspect except on employment. It did not also guarantee a temporary special measure in the area of health.

The 2005 criminal law expands abortion law which is an essential in guaranteeing the reproductive decision and autonomy of WWD. The code also criminalizes FGM and GBV which complies with its obligation under the CEDAW and other documents. However the penalty for violation of FGM is 'a slap on the wrist' considering the permanent life threatening consequence on multiplying the disability of WWD.

Minister offices and statutory organization have insubstantial contribution for the protection of RHR of WWD. Any of these governmental bodies have a disaggregated data based on sex, disability and age to identify the magnitude of the problem and violation RHR of WWD. Mainstreaming women's right and PWD right in each sectorial government office is pivotal for the implementation of their right; however the rights of WWD is neither mainstreamed nor respected in law and practice. MWCA and MoLSA respectively do not monitor these inadequately. Ethiopia has no Disability Act. MoLSA has a national plan of action on disability. MWCA formulated women development and change strategy with its package. However, these strategies and action plans are not supported by a specific legal framework. Financing and budgeting for WWD or PWD in the area of reproductive health is not clearly set in the national strategy of MoH. The involvement of CSO and DPOs in the advocacy, promotion and implementation of the RHR of WWD was not available. However the promulgation of the new proclamation on civil societies has paved a new opportunity to involve in this regard.

WWD are persistently confronted with barriers to reproductive health services, information and education. These constraints are of multifaceted and complex. The researcher concluded the

following as major barriers which result in the violation of their right; Lack of awareness on the RHR from both the women and the health care provider or professional, Stigma and wrong attitude of the society and the health professionals on the sexuality and reproductive health care needs of WWD, limited knowledge of health professionals on need based service to WWD as a Inaccessibility of infrastructure, unavailability of medical equipment and information tailored in accessible format such as brail and sign language.

Barriers to access the legal system presuppose the existence of a justiciable right. The researcher concludes that RHR are normatively justiciable in Ethiopian legal system, the judiciary has never entertained any case related to RHR. The enforcement of RHR in the legal system is challenging in the existence of many barriers. The study determines barriers to access justice have precluded WWD keep violation of RHR rights silent which furthers their vulnerability. The mere existence of legal aid centers and legal clinics in the universities insufficiently address access to justice by WWD as they are not equipped with expertise, materials and adequately funded.

4.2 Recommendation

The following recommendations are generated to improve the reproductive health rights of women with disabilities. The recommendations are directed to the government and the CSO or DPO

4.2.1 Recommendation on the legal and Policy framework

- ✚ The normative definition of persons with disabilities shall be broad to construe the right as the human right model than the medical understanding of disability.
- ✚ The obligation for reasonable accommodation and temporary special measures to guarantee equality and non-discrimination among WWD in their right to RH should also be incorporated in the constitution and other domestic laws to suffices the compatibility with other international organizations
- ✚ Disability as an evolving and contemporary concept should be clearly set as a ground for non-discrimination and equality before the law and for equal protection of the law
- ✚ The listing of reproductive health components should be exhaustive to include other components such as the right to access quality reproductive health care (pre and post

maternal health care), comprehensive sexual education and, safe abortion , the right to be protected from Sexual transmitted infections and HIV AIDS.

- ✚ The penalty prescribed in the criminal code for the violation of FGM and GBV should be aggravated to deter the criminal act promptly
- ✚ The national policies, strategies and plan of actions should be backed up by legal frame work to ensure its persuasiveness.
- ✚ A national disability act should be promulgated in order to address the issue of PWD in general and the delicate rights of WWD
- ✚ The state should adopt a national disability awareness strategy to curb the stigmatization and stereotyping of WWD in their right to reproductive health care and services. This will also curtail the discriminatory service provision by health professionals
- ✚ Review its building code and implementation of laws and directives on infrastructure accessibility in order to raise the practice of reproductive health services.
- ✚ Ethiopia should adopt a comprehensive plan of action and standards on accessibility, including accessibility of transportation, information and communications.
- ✚ Make sign language the official language of Ethiopia in order to overcome communication barrier.
- ✚ The government should work with international financial assistant agencies with progressive sustainability in mind

4.4.2 Recommendation on the institutional framework

- ✚ Women's right including RHR of WWD should be adequately mainstreamed in all institution in law and practice.
- ✚ The minister offices that are in charge of overseeing, monitoring and supervising the mainstream of women's right should actively fulfill their obligation
- ✚ Financing and budgeting for reproductive health should be clearly described and prorated in accordance with the need of WWD. This will address barriers in availability of medical equipment like adjustable bed, conducive latrine and in overcome the communication barrier by having interpreter or any assistive device.
- ✚ Data gathered should be disaggregated by disability in addition to age and sex in order to identify the needs of WWD in general and in SRH in particular.

- ✚ Awareness both on their reproductive health and right should be conducted to the women themselves, the health and legal professionals
- ✚ Effective procedural accommodation should be furnished for the realization of their right to access justice.
- ✚ Hospitals and health care staffs, law enforcement staff should be given compulsory and regular training on the rights of women with disabilities such as free and consulted consent on the administration of family planning , HIV and other health status of WWD for health professionals and
- ✚ Comprehensive sexual education and information should be available in an accessible format for WWD
- ✚ The Ministry of Education shall incorporate in its sexual education curriculum the special need and right of WWD

4.2.3 Recommendation on DPO and CSO, concerned stakeholders

- ✚ DPOs, CSO and other stakeholders like the UN bodies, legal researchers, higher education legal aid centers should all work hand in hand for the realization of RHR of WWD
- ✚ DPOs and CSOs should take advantage of the new CSO law voraciously to minimize the magnitude and prevalence of violation to RHR of WWD

BIBLOGRAHY

I. Books

- # Hofrichter, Richard. "Tackling health inequities: A framework for public health practice." *Tackling health inequities through public health practice: Theory to action* (2010)
- # Neuman, William Lawrence, and Karen Robson. *Basics of social research*. Toronto: Pearson Canada, 2014.
- # Creswell, John W., and J. David Creswell. *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications, 2017.
- # Willig, Carla. *Introducing qualitative research in psychology*. McGraw-hill education (UK), 2013.
- # Babbie, Earl R. *The practice of social research*. Nelson Education, 2015.

II. Articles

- # Kleiman, Susan. "Phenomenology: To wonder and search for meanings." *Nurse researcher* 11, no. 4 (2004).
- # Gable, Lance. "Reproductive health as a human right." *Case W. Res. L. Rev.* 60 (2009): 957.
- # Is the emperor still naked? Why the protocol on the Rights of women in Africa leaves women in Africa to more discrimination, *VANDERBILTS Journal*, Vol 42.2009,
- # Belayneh Admasu, Legal Protections Accorded to Persons with Disabilities under Ethiopian Law, *Bahir dar University Journal of law*, Vol 3 no 2, 2013
- # Meaza Yirga et al , Assessment of family planning need of Women with disabilities, USAID & Ministry of Health, 2017
- # Zucker, Donna M. "How to do case study research." *School of nursing faculty publication series* (2009): 2.
- # Baart, Judith, and Florence Taaka. "Barriers to healthcare services for people with disabilities in developing countries: A literature review." *Disability, CBR & Inclusive Development* 28, no. 4 (2017): 26-40.

III. Documents

- ✚ ICCPR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York
- ✚ ICPD program of Action Cairo, Egypt, Sept 5-13, 1994
- ✚ ICESCR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York
- ✚ CEDAW, adopted by the UN General Assembly in resolution 34/180 of December 1979 at New York
- ✚ CRC, adopted by the UN General Assembly in resolution 44/25 of 20 November 1989 at New York
- ✚ CRPD, United Nations Convention on the Rights of Persons with Disabilities adopted by General Assembly resolution 61/106 of 13 December 2006
- ✚ UDHR, adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris
- ✚ Vienna Convention on the Law of Treaties, (1980)
- ✚ General comment No.22 (2016) on the right to sexual and reproductive health, (Article 12 of the International Convention on Economic, Social and Cultural Rights)
- ✚ Declaration on the Rights of Disabled Persons, proclaimed Dec. 9, 1975
- ✚ World Programme of Action Concerning Disabled Persons, adopted Dec. 3, 1982
- ✚ Protocol to The African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, adopted in 2003
- ✚ Standard Rules on the Equalization of Opportunities for Persons with Disabilities, General Assembly resolution 48/96 of 20 December 1993
- ✚ Standard Rules on the Equalization of Opportunities for Persons with Disabilities, Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993
- ✚ World Health Organization(WHO), International Classification of Functioning, Disability and Health(ICF), Geneva, (2001)
- ✚ Principles Relating to the Status of National Institutions (The Paris Principles) Adopted by General Assembly , Paris, December 1993

- # Optional Protocol to the CRPD, adopted by General Assembly resolution 61/106 of December 2006
- # Proclamation No. 568/2008, Right to Employment of Persons with Disability Proclamation, FDRE, 2008
- # FDRE Criminal justice Policy, 2011
- # The Revised Criminal code , FDRE , 2005
- # National Plan of Action on inclusion of persons with disabilities, 2012-2021, MOLSA, 2012
- # Proclamation 210/2000, Proclamation to Provide for the Establishment of the Human Rights Commission, FDRE, 2000
- # Ethiopian Women development and change strategy and Ethiopian Women development and change package , Ministry of Women and children Affairs, 2017
- # Federal Attorney General Establishment proclamation 943/2016, 2016
- # Federal Courts Advocates Licensing and Registration Proclamation 199/2000
- # Proclamation no 1113/2019 Civil Societies organization, FDRE 2019

IV. Researches an discussions

- # Lee, Kira, Alexandra Devine, Ma Jesusa Marco, Jerome Zayas, Liz Gill-Atkinson, and Cathy Vaughan. "Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines." *BMC women's health* 15, no. 1 (2015)
- # Mekedes F. Libasie; Implementation of Women’s Right to Reproductive Health in Ethiopia; Policy and Heath care perspective; University, 2016
- # Aytnew ,D; The rights of persons with mental disabilities to access mental healthcare and their human rights conditions in psychiatric facilities in Ethiopia, Unpublished , Addis Ababa University, January, 2013

V. Interview

- # Mrs. Meaza Wolde , Women and children directorate director, interview conducted May 21, 2019, Addis Ababa
- # Mr Merid Mengesha, Team leader , Rehabilitation and Services Promotion, MOLSA, interview conducted May 21, 2019, Addis Ababa

- ✚ Mr Seleshi Tadess, Director, Women mobilization and participation enhancement Directorate, Ministry of Women and Children, Interview conducted May 22, 2019.
- ✚ Tigist Nadew , Intern , ENAD, conducted on May 7, 2019, Addis Ababa
- ✚ Selamawit Tessema , social worker , EWDNA, conducted on May 9, 2019, Addis Ababa
- ✚ Mrs Amsale Fufa , Inclusive Health Project Coordinator, ECCD , conducted May10, 2019
- ✚ Mr Tofic Yenus, Preseident , ENAD, conducted May 7, 2019, Addis Ababa
- ✚ Tekalegne Duge, Addis Ababa Public Prosecutor Office , Public Prosecutor interview conducted on May 26, 2019, Addis Ababa

VI. Cases

- ✚ CEDAW Committee, Concluding Observations: Hungary, U.N. Doc. CEDAW/C/HUN/CO/7-8 , (2013).
- ✚ Human Rights Committee, Concluding Observations: Guatemala, U.N. Doc. CCPR/C/GTM/CO/3 (2012); Dominican Republic, paragraph 15, U.N. Doc. CCPR/C/DOM/CO/5 , (2012)
- ✚ A.T. V Hungary CEDAW Committee No2/2003, U.N. Doc. CEDAW/C/32/DD/2/2003, (2005)

VII. Reports

- ✚ Manjoo, Rashida ; Report of the Special Rapporteur on violence against women, its causes and consequences; UN General Assembly; UN Doc. A/67/227, 2012
- ✚ Hunt .P; Report of the special rapporteur: The right of everyone to the Enjoyment of the Highest Attainable standard of Physical and Mental Health;UN. Doc.E/CN/4/49,2004
- ✚ The Central Statistics Agency of Ethiopia, CSA, (2007)
- ✚ OLINDA BAREIRO-BOBADILLA, Expert member from Paraguay, speaking in the report examination of CEDAW , July 2011

VIII. General comments , recommendations, and Concluding observations of Committees

- ✚ ICESCR committee, General comment No.22 on the right to sexual and reproductive health, Article 12 of the International Convention on Economic, Social and Cultural Rights, (2016)
- ✚ ICESCR committee, General Comment No. 14: on The Right to the Highest Attainable Standard of Health, Art. 12 of the convention , 2000
- ✚ CEDAW Committee, General Recommendation 24 on the Elimination of Discrimination against Women, Article 12 of the Convention, (2003).
- ✚ ICESCR Committee, General Comment No. 3 on the nature of States parties' obligations ,(2008)
- ✚ CEDAW Committee , General Recommendation No. 25: on Temporary special measures, Article 4 of the Convention, 2004
- ✚ CEDAW Committee, General Recommendation No. 21: on Equality in marriage and family relations, (2008).
- ✚ CEDAW Committee ; General Recommendation No. 19 on Violence against women, (1992)
- ✚ CEDAW Committee ; General Recommendation No. 35 on Violence against women, (2017)
- ✚ CRPD committee on the right of persons with disabilities , concluding observation on Ethiopia on its initial report, 16th session,(2016)
- ✚ CEDAW Committee Concluding observation on the report of Ethiopia on issues related to CEDAW, 72 session, (2019)
- ✚ CESCR committee , Concluding observation on Ethiopia, 48th session , (2012)

IX. Internet sources

- ✚ UN Office of the High Commissioner for Human Rights (OHCHR), *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions Published jointly with UNFPA and the Danish Institute for Human Rights* , 2014
- ✚ CESCR issues guidance on right to sexual and reproductive health, 2016 available at <https://ijrcenter.org/2016/03/16/the-cescr-addresses-the-right-to-sexual-and-reproductive-health/>
- ✚ Reproductive health indicators, Guidelines for their generation , interpretation and analysis for global monitoring, WHO, https://apps.who.int/iris/bitstream/handle/10665/43185/924156315X_eng.pdf;jsessionid=62BA4CD63421AA370931A485928A640D?sequence=1 accessed on April 7, 2019
- ✚ Disability Rights in Ethiopia; the situation of persons with disabilities. Sida , 2014 available at <https://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-ethiopia.pdf> accessed on May 24, 2019
- ✚ Ethiopia, Definition, number and type of disability; Dutch coalition in disability and development ,2019 available at <http://www.dccd.nl/lobby/definition-and-numbers-and-types/> , Accessed on May 24, 2019.
- ✚ Sexuality and Disability in the Indian context , working paper, TARISH 2018 available at <http://www.tarshi.net/inplainspeak/tarshis-corner-working-paper-sexuality-and-disability-in-the-indian-context-2018/> accessed on April 5, 2019
- ✚ A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice , Asian communities for Reproductive Health , 2005 :<https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf> accessed April 28, 2019
- ✚ Frans Viljoen, An introduction to the Protocol to the African Charter to Human and Peoples right, 2009 available at <http://law2.wlu.edu/deptimages/Journal%20of%20Civil%20Rights%20and%20Social%20Justice/Frans%20Viljoen.pdf> accessed on May 4, 2019

- ✚ Commission on Human Rights Resolution: 2004/27 states: ‘Considering that sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, available at: http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2004-37.doc.> accessed May 11, 2019
- ✚ Progress in sexual and reproductive Health Research, FGM- new knowledge spurs optimism, No 72, WHO. available at https://www.who.int/reproductivehealth/topics/fgm/progress72_fgm.pdf accessed on May 24, 2019
- ✚ Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities, Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women ,2018, paragraph 2 available at <https://www.ohchr.org/Documents/HRBodies/CRPD/Statements/GuaranteeingSexualReproductiveHealth.DOCX> , accessed on May 13, 2019
- ✚ Women Enabled , Submission to the Special Rapporteur on Violence against Women, its Causes and Consequences: Mistreatment of and Violence against Women and Girls with Disabilities in Reproductive Health Care, Including Facility-based Childbirth, 2019, pp2, available <https://www.womenenabled.org/violence.html> accessed May 28, 2019
- ✚ Situation of women and girls with disabilities and the Status of the Convention on the Rights of Persons with Disabilities and the Optional Protocol, UN General Assembly , 2017, paragraph 21 available at <https://www.google.com/search?q=Geneder+based+violence+in+reproductive+halth+of+women+with+disabilites&oq=Geneder+based+violence+in+reproductive+halth+of+women+with+disabilites&aqs=chrome..69i57.26644j0j8&sourceid=chrome&ie=UTF-8> accessed On May 23, 2019