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Shaping Sexual and Reproductive Health and Rights for Persons with Disabilities

A Policy Discourse Analysis of SRHR Policies from the African Union

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Abstract

Sexual and Reproductive Health and Rights (SRHR) is suggested to be solved by policies and action plans. However, post-structural scholars argue that discourses shape policies, and their solutions. The policy discourse on women with disabilities' SRHR needs has not been given much attention, especially in the context of Africa. Therefore, this study questions how SRHR is represented in relation to women with disabilities, specifically concerning contraception, gender-based violence (GBV), socio-environmental aspects and information, education and communication (ICE). To answer this, it draws on four questions from Bacchi's post-structural 'What's the Problem Represented to be?'(WPR) approach. Three primary policy documents produced by the African Union are selected for policy discourse analysis.

The findings suggest that the SRHR discourse continues to be represented along the lines of reproductive health. Contraception is encouraged and represented as an individual choice, but disregards unequal power relations in society. GBV is problematised in terms of legal strengthening, and women with disabilities seem to be constituted as SRHR subjects through the problematisation of GBV. SRHR is moreover represented in terms of a rural-urban binary, which mystifies disabling social structure. This is also noted in ICE for SRHR, representing homogenous service and a silent able/disable dichotomy.

Key words:
African Union, discourse, power, policy analysis, problematisation, subjects, SRHR, women with disabilities, WPR approach

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List of abbreviations

AU – African Union
CPF – Continental Policy Framework on Sexual and Reproductive Health and Rights
CRPD – Convention on the Rights of People with Disabilities
GBV – Gender-Based Violence
GEWE – Strategy for Gender Equality & Women's Empowerment for 2018-2028
ICDP – International Conference on Population and Development
IEC – Information, Education and Communication
ICPD – International Conference on Population and Development
LMIC – Low Middle Income Countries
Maputo Protocol – Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa
MPoA-2007 – Maputo Plan of Action 2007-2010/ 2015
MPoA-2016 – Maputo Plan of Action 2016-2030
RMNCAH – Reproductive, Maternal, Newborn, Child And Adolescent Health
SDH – Social Determinants of Health
SRH – Sexual and Reproductive Health
SRHR – Sexual And Reproductive Health And Rights
SRH& RR – Sexual And Reproductive Health And Reproductive Rights
WPR – What’s the Problem Represented to Be

1. Introduction

Policy analysis often set out to guide the activities of governments and their populations; to make life better (Daniell et al., 2016). The needs and demands of people, however, fluctuate and are impacted by the changing social, economic and political surroundings. Policy analysis can therefore inform what must evolve (Mayer et al., 2004; Enserink et al., 2013). Today, a dominant paradigm in society presents a 'problem-solving approach' (Koppenjan and Klijn, 2004). This transfers to policy analysis, believing that every problem, temporarily or permanently, can be solved through policy analysis (Wildavsky, 2018).

However, the notion of 'problem-solving' is challenged by a discursive view of policy analysis as it invites us to think about what meaning is given to a problem (Colebatch, 2005). The discourse perspective inquires how policies are affected by surrounding conditions, by the views that circles in society (Forester and Fischer, 1993; Rein and Schön, 1996). These questions invite us to study the 'problems' in policies and what makes policies shape their 'solutions' in a certain way and not another.

In this view, 'problems', which policies set out to solve, are not simply stumbled across. Instead, we need to question how specific issues are thought about and problematised (Bacchi, 2012). Policy discourse analysis is a novel way to approach this. It enables us to question how a problem is understood by decision-makers and what meanings lodge behind it.

One of these 'problems' that achieve different levels of attention over the decades yet remain sensitive, complex and fluctuating, is the topic of 'sexual and reproductive health and rights (SRHR)'. It is also multifaceted as it balances human rights and health dimensions (Brown et al., 2019; Ferguson et al., 2019). The current discussion on its content and conceptualisation was brought forward in the International Conference on Population and Development (ICPD) in 1994 and followed up in the Millennium Development Goals (MDG). Now the Sustainable Development Goals 3.7 and 5.6 (SDG) aim to guarantee women's SRHR needs, demonstrating that this issue continues to be relevant (Gostin et al., 2020).

One group that faces multiple challenges to access their SRHR is women with disabilities, especially in an African context (Mavuso and Maharaj, 2015; Rugoho and Maphosa, 2017). Although policy analysis of disability in Africa has been done in relation to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)(Aldersey and Turnbull, 2011; Fernandez et al., 2017), the issue of SRHR intersects both gender barriers and disability-based discrimination. Negative perceptions, inaccessible facilities and lack of information persist, even when SRHR policies are assumed to be in place (Ahumuza et al., 2014; Lang et al., 2019). Studies about their representation, as subjects, in SRHR policies are nevertheless absent.

As a governing body of the second largest and second most populated continent, the African Union (AU) has the power to shape certain discourses through its policies and affect how 'SRHR' are thought about. In 2003, the AU's member states adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol). It is regarded as a vital document to protect women's SRHR and coined the fastest ratified treaty in the history of AU (Ngwena, 2010; Mohamed, 2014). Yet, many member states have reservations, usually concerning SRHR (Van eerdewijk et al., 2018). This gives rise to approach policy analysis through a critical perspective and investigate how these issues are understood and problematised in the first place.

1.2 Aim

This thesis sets out to approach policy through discourse analysis, thereby applying a 'problem-questioning' perspective. This research aims to investigate the dominant discourses within 'SRHR' policies from the AU. I do this by specifically examining contraception, gender-based violence (GBV), information, education and communication (ICE) and socio-environmental aspects and their relationship to women with disabilities. Bacchi's (2009) post-structural critical policy analysis method – 'What's the Problem Represented to be?' (WPR) aids this. Rooted in Foucauldian discourse analysis, attention is on problematisations and subjects in a discourse; produced by power and knowledge practices. I utilise four out of the six guiding questions within the WPR approach which are useful for my aim and consider what assumptions might underpin a problem representation and inquire what effects certain representations may have on women with disabilities. Thus, to meet the research aim, the following research questions will be answered:

- How is ‘SRHR’ represented in the policies of the African Union?
- How are women with disabilities constituted through this problem representation?

This policy discourse analysis of SRHR and women with disabilities are anticipated to contribute to the broader field of policy analysis and international policy development by questioning and inviting a more integrated analysis of policy premises and the effects of certain problem representations.

Finally, the study understands ‘disability’ in terms of a social model of disability (Oliver, 2013) in which ‘disability’ becomes a problem due to societal barriers such as physical, social, political or communicational barriers (see section 2.5). However, the focus is on how women with disabilities are understood in the AU’s SRHR discourse, not how SRHR is represented in the disability discourse. ‘Persons with disabilities’ is written out in its full length to signal the people behind the meaning rather than labelling or reducing a person to an abbreviation (Logeswaran et al., 2019).

1.2 Disposition

Guided by the aim and research question, the following chapter sets the scene for the study through previous research. Chapter 3 presents the post-structural perspective based on the analytical approach of WPR. It highlights knowledge practices, problematisations and the role of subjects. The subsequent chapter explains WPRs methodological aspects and questions alongside the research design, which describes how these are used in the data selection and analysis. Chapter 5 presents the contextual background and provides a contemporary setting of SRHR in relation to AU before the analysis. The following chapter presents the findings and analysis in a combined approach to answer the research questions. Chapter 6 concludes the study and suggests further research.

2. Literature review

This chapter outlines the contemporary field of policy analysis and health policy research in particular. It presents a discussion of SRHR and continues by highlighting disability in relation to SRHR. It concludes by drawing attention to vulnerability.

2.1 Views on policy analysis

Public policy analysis has different approaches based on epistemological perspective. Some view the policy-making process in a consequential manner, which broadly includes problem identification, policy formulation, implementation and evaluation (Walker, 2000). Others claim policy to be a process of decision-making while also being a product of that process, which depicts the policy process as a course of action over time (Wildavsky, 2018:421).

Problem framing, its priority advances on the policy agenda and how the policy is formulated are other aspects of the policy-making process (Sabatier, 2007). Kingdon (2014) focuses on problem framing in his ‘Multiple Streams Theory’ model. He argues that problem, politics and policy streams operate in parallel, except when a ‘window of opportunity appears. When the problem, politics and policy align, it gets certain issues on the policy agenda. This lens guides the ‘Health in All Policies (HiAP)’ approach, promoted by the WHO for health development assistance, as the problem stream draws attention to the issue, the policy stream proposes technical solutions, and the political stream demonstrates the surrounding knowledge and environment (Leppo et al., 2013). However, the model has been viewed as limited in its usefulness but suitable for explaining agenda-setting (Zahariadis, 2007). Policy framing can also be used to interpret what meaning is given to policy texts. It focuses on the promises of governments, compared to what is actually delivered, thus underlining the linguistic and rhetorical dimensions of the text (Scrase and Ockwell, 2010; Hansson, 2015)

Social constructionist approaches to policy analysis take external social contexts and power into account to understand policy processes (Pierce et al., 2014). Van Aswegen et al. (2019) furthermore draw on Foucauldian theories in their critical discourse analysis framework and policy problematisation approach of disability policies in Ireland.

2.2 Policy as a discourse

Opposite to more common practices of policy analysis, the Foucauldian approach to policy research investigates the discourses that surround policies rather than the policies themselves. The use of ‘discourse’ in this study is elaborated in the following theory chapter (see 3.1). In policy sociology, it has been a method to switch focus from ‘people make policy’ to ‘policy makes people’ (Ball, 1993, p. 14). Policy as a discourse, therefore, shed light on how power is exercised. Power produces different forms of ‘knowledge’, understood as discursive practice. In turn, this affects what can be said, thought and done (or not) by us, as we are the discourse (Ball, 1993). This relates to the research question of how SRHR is represented. Central in this type of discourse analysis is the different ‘subject positions’ we take up, which are (re)formed through policies. For example, both teachers and students are given certain positions in education policies, reflecting and shaping their social relationship while also structuring how education can be thought and spoken about (Ball, 2015). According to this view, discursive practices and power relations form subjectivity, which is relevant when investigating how women with disabilities are constituted through SRHR representations.

2.3 Health policy research

Developed specifically for health policies, which SRHR could fall under, is the ‘Policy Triangle Framework’ by Walt and Gilson (cited in Walt et al., 2008). It captures the context, content and process of policy-making while also shedding light on actors involved, such as individuals, groups and organisations. This critical approach has been used to assess policies by exploring why a policy is needed, its content, how it is brought forward and who participates in the various phases. Using this analysis, Tour et al. (2012) found a historical shift in policies from the AU with increased coverage of maternal and child health. Their results show that human rights discourse is most often used to frame the health of women and children.

Designing “healthy public policies" has the intention to ensure health equity by reducing disparities between groups based on social, economic and political constraints (Embrett and Randall, 2014). Incorporating aspects outside the health system into policies means awareness of social determinants of health (SDH). Exworthy (2008) argues that SDH carries several challenges, which may impact the policy-making process. The social determinants of sexual and reproductive health (SRH) include social factors such as living and working conditions; education level; economic status, and health care systems (Malarcher and WHO, 2010). In India, attitudes, traditions and cultural norms are observed explicitly as social determinants of SRH (Rao et al., 2012). Policy practices and research developed in high-income countries (HIC) should, however, not be transferred undisputed to low and middle-income countries (LMIC) (Exworthy, 2008). Although, regardless of spatial context, policy models are argued to shed light on critical issues in the policy process, such as power and resistance (ibid).

Nowadays, evidence-based research takes a predominant role in policy-making, such as knowledge translation (KT), promoted in African countries to inform health policy formulation (Edwards et al., 2019). KT is suggested to make clinical and health-service research more relevant and transferable into practice, politics and policy (Wensing and Grol, 2019). In contrast, Murphy and Fafard (2012) criticise KT strategies within urban health equity research and recommend a discourse analysis approach for theorising power in policy-making. Conducting policy-analysis through a post-structuralist lens challenges what is viewed as a ‘problem’ and questions the ontologically rational way of perceiving ‘knowledge’ as uncontested (Lister, 2010). Evidence-based approaches in policy-making have nevertheless become a form of ‘knowledge’, which may impact how ‘problems’ are represented in health policies (Bacchi, 2016) (see section 3.1.1 for ‘knowledge’).

2.4 Comprehending SRHR

The introduction highlighted the 1994 ICPD and the adoption of its Programme of Action (UN, 1995a) is oftentimes viewed as a starting point for ensuring SRHR for women and girls. Dominated by a rights-based framework, reproductive health is defined 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. 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. (UN, 1995a:40)

In turn, reproductive rights rest on pre-established human rights conventions, meaning all individuals and couples have the right to make decisions concerning reproduction and live free from violence, coercion and discrimination. Due to women's reproductive capacities, SRHR contains a specific gender perspective. The Fourth World Conference on Women (FWCW) in 1995 produced the Beijing Declaration and Platform for Action. It contained aspects of reproductive and women's health respectively and cemented women's rights as human rights (United Nations, 1995b). It was stated that participants added that SRHR should include "mutual respect, consent and shared responsibility for sexual behaviour and its consequences" while it requires equal relations between women and men in matters of sexual relationships and reproduction (Gostin et al., 2020, p. 312). Findings in Nigeria echo shared responsibility and communication between spouses on contraception and childbearing, while men are portrayed as significant decision-makers (Ogunjuyigbe et al., 2009; Akaba et al., 2016). Bietsch (2015) study from sub-Sahara makes a similar observation that women's contraception use depends on men's attitudes.

SRHR is consequently interlinked with other human rights such as the right to life and survival; autonomy and confidentiality; information and education; equality and non-discrimination; and right to bodily and psychological integrity (Miller et al., 2015). General Comment no.14, under Article 12, moreover points out that SRH services must be available, accessible, affordable and of good quality (CESCR, 2000). This was re-emphasised in General Comment 22, which specifically underlines the right to sexual and reproductive health (CESCR, 2016). It has nevertheless been argued that SRHR are not new rights (Cook and Fathalla, 1996).

To sum up, SRHR have been claimed to include maternal health, the ability to make decisions about reproduction such as family planning and contraception, preventing unsafe abortion, protection against sexual transmitted diseases including HIV/AIDS, being free from GBV and entitlement to information and education in the form of comprehensive sexuality education (CSE) (Gebhard and Trimiño Mora, 2011; Temmerman et al., 2014). It, therefore, incorporates both health services (SRH) and rights aspects (SRHR) (UNFPA and WEI, 2018). However, it is observed that the difference between SRH and SRHR creates confusion and can be viewed as an obstacle in policy operationalisation (Oronje et al., 2011). Their findings, based on three case studies from sub-Sahara Africa, indicate that prohibitive laws, reluctant governments that lack the political will and ideological opposition are significant obstacles. Nonetheless, Oronje et al. (2011) highlight how different actors manage the challenges by strategic framing and opportunism, which could be referred to as a “window of opportunity” (Kingdon, 2014).

In the discussion on CSE and its rights-based approach, it is claimed that CSE takes a Eurocentric approach in framing subjects, which is contradictory to the cultural context it claims to be sensitive to (Roodsaz, 2018). Adding to this is Coultas et al. (2020) study on Tanzanian youths. It analyses how culture relevance and knowledge of ‘Others’ are incorporated in CSE and how this knowledge is perceived and related to by different groups of young Tanzanians. They argue that all research subjects found CSE knowledge to be ‘Other’, Western, independent of the demographic group although based on different reasoning depending on the youth’s socio-economic positions. Tumwine et al. (2020) complement this, investigating whether cultural and religious attitudes influence healthcare workers in LMIC. The findings reveal this hypothesis to be inferior as individual characteristics such as knowledge-seeking assume to guide their SRHR attitude and practice. This research signals how surroundings may shape the SRHR discourse.

Going back, Klugman (2000) suggests that the ICPD and FWCW achieved a consensus on reproductive rights. However, opposition remains, and sexual rights are referred to without using the exact terminology. She highlights gender equality, the impact of religion and development priorities as underlying discourses within SRHR. These, among other arguments, affect the discussion on sexual rights concerning HIV/AIDS in Southern Africa (ibid). The HIV/AIDS discourse in relation to women has centred on preventing transmission to the infant, placing women’s health needs secondary (Eyakuze et al., 2008). Hopkins and Collins (2017) make a similar claim, noting that elimination of mother to child transmission of HIV is included most often while SRHR of persons, especially women, living with HIV and AIDS get the least attention out of 60 country strategies. Nampewo (2017) study in Uganda moreover highlights the gaps that persist for persons with disabilities in accessing SRHR in regards to HIV. Going further, domestication of international agreements; increased budget allocations; improved human resource capacity and innovative, evidence-based research to position SRHR politically are often uplifted as solutions to advance the ICPD in an African context (Okonofua, 2020).

Waldman and Stevens (2015) analyses South African mHealth policies and projects, focusing on information communication technologies (ICT) and the intersection with SRHR. They find that more contested aspects, such as adolescent sexuality and abortion, tend to be avoided while addressing more medical and less disputed areas such as pregnancy, childbirth and motherhood. The latter is explained as “safe topics” (ibid: 98). The discourse on SRHR itself is not homogenous, and authors note the topic’s sensitivity, especially concerning traditional, cultural and religious opposition. Eniola and Aremo (2020) bring attention to patriarchal norms when they explore ‘bride price’ and SRHR in Nigeria and South Africa. The need for partner’s or parents' consent or involvement in obtaining contraception is noted as an obstacle in other sub-Saharan African countries (Bahamondes and Peloggia, 2019; Kibira et al., 2020).

2.5 Disability

To understand how women with disabilities are constituted through SRHR problem representations, we must first underline that conceptual models of disability have shifted through time and places. These models shape how institutional systems, governments, and societies view and relate to persons with disabilities. Historically, the medical model of disability perceived a disabled body to “deviate” from the “normal body” in its functions, related to disadvantaged impairments (Olkin, 2001). In this kind of clinical framework, disability carries a non-political notion and is centred on the individual setting for persons with disabilities. This understanding has led to stigmatisation and social exclusion of persons with disabilities (Mitra and Sambamoorthi, 2006).

In contrast, the social model of disability emerged in the discussion. It stems from social and political arguments stating that their impairments should not disable persons with disabilities but the disabling surroundings in society causes it (Oliver, 2013). So, while the medical model relates to individual limitations, the social model links to structural restrictions and social exclusion (Shakespeare, 2006). Thus, the responsibility to assist is placed on society instead of the individual, as the barriers are socially created. However, two weaknesses exist in the social model of disability (Oliver, 2013). Firstly, the room for acknowledging impairments are missing since these may, in fact, be disabling. For example, absence or difference in bodily structure can result in difficulties with bodily functions. Secondly, the narrow and homogenous understanding of disability fails to see intersecting and social differences within disabled persons such as race, gender, ethnicity, age and sexuality (Oliver, 2013). Excluding impairments creates a one-dimensional view of the social model, and it has been argued that people are disabled both by their bodies and social barriers (Shakespeare and Watson, 2002, 2010). Now, a human rights model of disability, which takes its stand in everyone's inherent dignity as humans, has been argued to complement the social model (Lawson and Beckett, 2021).

The two latter models resonate with the UN Convention on the Rights of Persons with Disabilities (UNCRPD), endorsed in 2006, which was the first legally binding international document with obligations to protect and promote the rights of persons with disabilities (UN General Assembly, 2007). However, in Lang et al. (2019:156) policy analysis of documents from the AU, it is argued to be an apparent "disconnect" between the rights of persons with disabilities and their inclusion in policies, guaranteed through the ratification of the UNCRPD.

Marshall (2012) goes further by problematising 'disability mainstreaming' and 'inclusive development' in the material produced by the World Bank through a WPR approach (see chapter 3). She detects limitations within the concept of 'inclusive development' and a 'problem' of awareness, prevention and social integration. Significant is her contribution on reflexive practices and the challenges of (re)producing hierarchical binary narratives regarding developed/developing, disabled/abled and included/excluded (ibid).

2.5.1 Disability & SRHR

Studies find that persons with disabilities often are assigned to be asexual, desexualised or hypersexual in an African context (McKenzie, 2013; Mavuso and Maharaj, 2015; Hunt et al., 2017). Although persons with disabilities have the same

SRHR needs as other social groups, they are often disclosed from information about it and discriminated against. This is the case in South Africa, which hinders development of healthy relationships to sexuality (McKenzie, 2013). Hanass-Hancock et al. (2018) study further seek to develop and provide CSE to persons with intellectual disabilities. However, they identify socio-cultural norms as persistent obstacles entwined in a protectionist discourse. Casebolt's (2020) review from LMIC identifies critical barriers to reproductive health for women with disabilities, focusing on service provision. It proposes policies mandating the inclusion of people with disabilities to be necessary (ibid).

Structural factors to access SRH services remain a significant barrier in LMIC. This refers to inter alia inaccessible facilities, lack of information, communication barriers and negative attitudes (Smith et al., 2004; Ahumuza et al., 2014; Burke et al., 2017). For instance, women with disabilities who had experienced childbirth in Zimbabwe reported urban and rural differences in the SRHR healthcare system, inadequate care during delivery, poor after-care information about infancy and insufficient information about contraceptive choices suitable for an individual's specific impairment (Peta, 2017). This challenge Trani et al. (2011) study from Sierra Leone, which found socio-economic inequality to govern access to contraception rather than disability. They also point out that women with disabilities desire to build and plan families, contrary to the misconception about persons with disabilities as sexually inactive. Therefore, these negative stereotypes must be challenged in order to advocate for equal access to SRH services (ibid).

However, already in the ICPD, persons with disabilities are recognised as a social group to eliminate specific forms of discrimination form. Non-academic literature has begun to include persons with disabilities in SRHR discussions and programmes, especially regarding accessible sexuality education and preventing and managing GBV (UNFPA and WEI, 2018). Research carried out in non-Western countries with a stronger intersectional perspective on disability and sexuality has been suggested to understand how people in different societies confront similar SRHR issues (Campbell, 2017). Carew et al. (2017) echo this recommendation. They find that the sexuality of persons living with disabilities in LMIC has attained low empirical investigation, and few experimental studies have been conducted. According to them, research on disability and sexuality in African countries has predominantly centred on sexual abuse and violence or HIV. Similar results are found in Hameed et al (2020) systematic review, maintaining that research tends to be set in an upper-middle-income setting, as opposed to very seldom in rural areas.

2.5.2 Vulnerability

There is a symbiotic correlation between ‘vulnerability’ and disability. Flaskerud and Winslow (1998) argue that vulnerable populations are “defined as social groups who have an increased relative risk or susceptibility to adverse health outcomes” (p.1). Vulnerability in health, which SRHR can fall under, must be understood in a multidimensional manner and intersectional dimension, meaning that certain characteristics intersect, depending on the social situation (Braveman and Gruskin, 2003). ‘Disadvantage’ is a similar concept to vulnerability and can be understood as power relations and groups’ ability to mobilise resources, which impact their ability to position themselves in social hierarchies (ibid). It also relates to populations being marginalised by social institutions (Azétsop and Ochieng, 2015). Persons subjugated to discrimination, intolerance and stigma based on experience from positionality due to social structures may be considered vulnerable or disadvantaged (Flaskerud and Winslow, 1998; Chinyama et al., 2018). Identifying and labelling groups subjected at risk to vulnerability is suggested as useful in public health policy since it is a means to allocate resources and establish who may be qualified for specific health interventions, special protection and social benefits (Ruof, 2004). Nevertheless, vulnerability is a contested concept, argued to be demeaning and risk labelling certain groups as ‘other’ (Danis and Patrick, 2002).

A study from 15 developing countries found persons with disabilities, especially over the age of 40, to be more likely associated with multidimensional poverty, often related to household socioeconomic deprivation (Mitra et al., 2013). The same scholars underline the causal link from poverty to disability and disability to poverty. Yet, it varies across disability types and contextual environment (ibid). However, according to Lang et al. (2011) a rights-based perspective does not render women, the elderly or persons with disabilities intrinsically vulnerable; instead it is the lack of access, information and support that exaggerates vulnerability.

Social positions interlinks, and according to Oxfam International (2020), women globally earn 24% less than their male counterparts and are at heightened risk to live in poverty. In addition, women as a group face certain risks such as unwanted pregnancy and more often suffer sexual abuse and GBV (McCloskey, 2016). Persons with disabilities have been coined more vulnerable to abuse than non-disabled people, and women with disabilities are at higher risk of being sexually abused, especially if they have an intellectual impairment (Hughes et al., 2012; UNFPA and WEI, 2018). Nevertheless, Eveline (1994) uncovers the conceptual dimension of advantage-disadvantage. She argues that the discourse of women's disadvantage in society fails to shed light on the advantages men gain, rendering it invisible.

To sum up, this chapter shows the different ways policy analysis is conducted, leading into the field of policy discourse analysis. The relationship between policy and SRHR is underlined, and previous studies related to SRHR and disability, displaying empirical research conducted in an African context. It concludes by linking disability to vulnerability. However, it is beyond the scope of this thesis to consider SRHR contestations for multiple social groups, albeit recognising their intersectional dimensions. Two contested concepts not covered in themselves are health and human rights. For example, McGrogan, (2018) claims human rights to be a regulatory tool to govern populations. A discussion on these separately is nonetheless beyond the scope of this study, but the following chapter shows how concepts, such as governance, is interpreted in this study.

3. Theoretical approach

A theory-seeking practice inspires this chapter because it acknowledges a multi-perspectival theoretical starting point (Ackerly and True, 2010). Bacchi's theoretical background echoes this since it draws from post-structural, post-colonial and feminist body theory (Bacchi, 2009). This perspective is used over others critical discourse analysis theories (Wodak and Krzyzanowski, 2008) due to its link across thematic areas and focus on 'knowledge' over language. The study uses the theoretical landscape of 'What's the Problem Represented to be' (WPR) regarding power, practices, problematisations and subjects, which also shape my methodological course of action presented in the following Chapter 4. For stylistic purposes, singular quotation marks are used as scare quotes to signal the post-structural premises of offering new perspectives on ‘problems’.

3.1. What’s the problem represented to be? (WPR)

The WPR approach rests on multiple theoretical underpinnings; many influenced by Foucauldian perspectives, but the basic premise is that “what we say we want to do about something indicates what we think needs to change and hence how we constitute the ‘problem’” (Bacchi, 2012, p. 4). Policies are therefore not developed and implemented in a political vacuum. Instead, Bacchi (2009) argues that policies hold implicit understandings and embedded assumptions of what represents the ‘problems’ they aim to address. A ‘problem’ is therefore produced as a particular sort of ‘problem’ within policies (Bacchi and Goodwin, 2016).

3.1.1 Problematisation, knowledge and discourse

Problematisation is viewed in terms of problem representations (Bacchi, 2012) and used interchangeably in this study. *Problematisation* refers to the products of governmental practices; emerging and affected by political and social practices (Bacchi and Goodwin, 2016p. 16). Therefore, policies can be interpreted as a product of practices since they are affected and produced by the surrounding discourses. This aligns with the Foucauldian understanding of *discourses* as practice (Bacchi, 2009). In this study, discourse is conceptualised as the connection between socially created ‘*knowledge’* practices and power relations (Bacchi, 2009; Goodwin, 2011). Knowledge is therefore understood as “what is accepted as true” (Bacchi and Goodwin, 2016:35). When ‘knowledge’ is socially produced, it affects, enables and limits what is possible to think, write and speak about in a specific social setting, given a particular object or practice.

Henceforth, the WPR approach sheds light on how meaning is made and how governance takes place through ‘knowledge’ practices and power relations, not only by states but also by other actors with power (Bacchi and Goodwin, 2016). This shapes how ‘problems’ are thought about. However, the intention of governing actors and policymakers is not the focus; instead, unfairness is implied in the current problem representation, not by casting blame on the authors of those systems, but the discourse in which it was created (Bacchi, 2009). The approach, therefore, carries a normative implication that some problem representations may harm or benefit certain groups. This could be perceived as a limitation for objectiveness. However, the approach is a valuable point of departure to study broader governance through policies. The study does not investigate governmentality per se; instead it looks at how, “Governing takes place *through* problematizations” (emphasis in original) (Bacchi, 2012: 5).

Since problem representations govern people, the focus is also placed on the effects of certain representations. In this study, *power* relates to the Foucauldian notion of disciplinary power and biopower. The former indicates regulations of the individual body, people’s activity and behaviour through self-surveillance, while biopower builds on this to incorporate managing the bodies of a population as a whole (Bacchi, 2009). It is thus concerned with the population as both a political and scientific ‘problem’. Power is however (re)produced and operates according to discourse, in relation to people's subject positions and surrounding social systems (Bacchi and Goodwin, 2016)

3.1.2 Subject positions and responsibility

In a Foucauldian manner, human beings and social groups are made into particular kinds of *subjects*, depending on the dominant knowledge within a particular discourse (Bacchi and Goodwin, 2016). These knowledge practices produce and impact how subjects ought to be and are thought about. In addition, it sets groups in opposition to each other, such as man/woman, able/disable, youth/ adult, to encourage a desired behaviour among the majority. This is known as *dividing practices*. Groups are also assigned position and value within policy discourses, which leaves the ones ‘holding’ power to define how groups without power are understood in the policies. We can therefore assume an implied hierarchy within *binaries* and *dichotomies*. In addition, there is a built-in implication of who is responsible for the ‘problem’ known as *attributions of responsibility* (Bacchi, 2009). The making of subjects is described as subjectification. Subject positions are not deterministic but plural and contradicting, and Bacchi (2000:54) highlights that subjects are “positioned in relation to multiple and contradictory discourses, opening up a space for change”.

Foucault's theoretical reasoning has however not been without opposition and it is argued to be contradictions within it (McCarthy, 1990). Other authors have drawn attention to the different understandings of subjects (Törrönen, 2001), some more general while others social and culture-specific, depending on schools of thought (Butler, 1997; Hall, 2011). Many of these concepts are also the foreground in feminist epistemology, which the WPR is influenced by due to its focus on inter alia privilege, positionality, knowledge hierarchies and experiences (Archibald, 2020).

3.2 Operationalisation

As problem representations mirror discourse, the theoretical point of departure centres on discursive practices, which shapes particular 'knowledges' of SRHR. It looks at how four particular SRHR issues are recognised and represented in the selected policies and asks how women with disabilities are constituted through this problematisation. Meaning how they are thought about through discursive practices. The concept of *'positions'*, in this thesis, refers to the active role policies play in making different subject positions 'available' (Bacchi, 2016).

Yet, Bacchi (2012) notes that theories, as practices, also produce problematisations that shape and create subjects. This is revisited in the concluding chapter 7. The WPR approach nevertheless offers an original way of studying policies that have not been deployed on this topic or in this context before. The approach proposes six guiding questions, which are adapted, to answer the research questions.

4. Methodology

This chapter explains the thesis research design and use of discourse analysis through the WPR approach. The strategy behind the guiding questions is presented alongside the data selection and methodological course of action. Limitations are noted alongside reflections on reflexivity.

4.1 Research design

This study takes a qualitative design and has an interpretivist epistemology since social realities are perceived as socially constructed and produced (Silverman, 2013:140). Although the WPR approach seems to take a central role in this study, it was not the original case. In fact, it entered the scene quite late. The original plan was to conduct qualitative research through interviews with women with hearing impairments and their access to SRHR in Tanzania. However, due to the Covid-19 pandemic causing travel restrictions and difficulties in obtaining a research permit and ethical clearance, the research plans changed. Instead, the 'field' was moved online along the lines of Gupta and Ferguson (1997:35) suggestion to conceptualise the 'field' as 'political locations' in opposed to 'spatial sites' (in Storey and Scheyvens, 2003:9). An inductive approach and the use of secondary data was therefore deployed (Bryman, 2012). It led me to collect national SRHR policy documents from East African countries, not informed by a theoretical framework. Discourse analysis was thereafter sourced, and the WPR approach found. Simultaneously, the search for SRHR policies in Africa was broadened, which led me to focus solely on AU.

4.2 WPR – methodological approach

Applying discourse analysis to policy analysis opens up new perspectives by questioning how 'problems' are represented, conceptualised and constructed within the policy (Bacchi, 2009:2). Six guiding questions are offered as a method for analysis but the approach has also been described as an analytical strategy since it "enable[s] the analyst to obtain knowledge that is critically different from the existing system of meaning" (Goodwin, 2011:172). Presented below are the original questions I draw inspiration from:

> Q1. What's the problem (e.g. of "gender inequality", "drug use/abuse", "economic development", "global warming", "childhood obesity", "irregular migration", etc.) represented to be in a specific policy or policies?
>
> Q2. What deep-seated presuppositions or assumptions underlie this representation of the 'problem'?
>
> Q3. How has this representation of the 'problem' come about?
>
> Q4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualised differently?
>
> Q5. What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?
>
> Q6. How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced? (Bacchi, 2009:48)

To answer how ‘SRHR’ is represented in the policies of the African Union, and how women with disabilities are constituted through this problem representation, the WPR Q1-Q2 and Q4-Q5 are useful. These can assist in investigating what key premises underpin certain SRHR representations, what enables this representation and what effects this may have on women with disabilities. For Q1-Q2, I take my starting point in the policies, while Q4-Q5 detects the silences and effects by using empirical academic literature. The data selection is presented in section 4.4 after a clarification of the guiding questions.

4.2.1 Methodological strategy behind the questions

Firstly, Q1 is a clarification exercise. It helps identify the implied problem representation in the data by shedding light on how the documents phrase, present, and address ‘SRHR’. The following Q2 assesses the conceptual logic and assumptions that lodge within the problem representation. Discourse analysis techniques, drawing from Foucauldian archaeology, assists in uncovering these (assumed) embedded key premises that lie behind a particular problem representation, which shapes the subject positions. Exposing what ‘taken for granted’ principles the policies rest upon is done by analysing sense and meaning-making related to knowledge practices. Hierarchical binaries and unquestioned key concepts are identified, which is argued to be a way of organising behaviour and people, to explore the conceptual underpinnings the policy is based on (Bacchi, 2009).

Parts of Q4 are used to reflect what is left out in the representation of SRHR inspired by Foucauldian genealogical analysis, highlighting how ‘problems’ are created in a certain way, shaped by history, social settings and relations (Bacchi and Eveline, 2010). Discourse analysis techniques are also used in Q5 to display the subjectification effect and dividing practices related to available subject positions within the policies and how groups are produced in opposition to each other (Goodwin, 2011:173). Q5 includes discursive effects, which relate to what can be said, thought and expressed and the lived effects, such as material impact problem representations may have (Bacchi and Eveline, 2010). Henceforth, it incorporates reflections of symbolic, material and lived effects of SRHR concerning women with disabilities. These effects invite critical considerations on what is likely to change or stay the same with a particular 'problem' representation and consider why some groups benefit and others are harmed by certain representations (Bacchi, 2009).

All six questions are not utilised but Q3 assists in tracing the origin of the policy presented in Chapter 5 to upset assumptions about a linear policy-evolution (Bacchi, 2009). Therefore, the contextual background is intentionally placed before the analysis to highlight conditions that allowed for a dominant problem representation to take place, inspired by Foucauldian genealogical analysis. To some extent, Q6 is viewed as a continuation of Q3 and is also excluded since it suggests to determine why certain problem representations dominate the current SRHR discourse, while others not, and proposes to mobilise efforts to reframe this. These questions are beyond the scope of my data, which is unable to inform me on these dimensions.

4.4 Data selection

This study understands policies as 'prescriptive texts', in line with Foucault's post-structural interpretation, which is any text "written for the purpose of offering rules, opinions, and advice on how to behave as one should" (Foucault, 1992). Policies are therefore understood as proposals for change in themselves (Bacchi, 2009). The policy selection indicates in itself a subjective practice of the researcher, according to Bacchi (2009:2). This is true in this study, as I already declared the prior geographical and thematic interest. Policies published in English and related to SRHR were therefore sourced online through an inductive approach previously mentioned. A hermeneutic approach is applied since the specific macro-context of AU, where the documents are produced, is brought forward (Bryman, 2012:560).

Furthermore, the AU is treated as a homogenous actor that conducts governance within the SRHR discourse (Bacchi, 2009:29). Any text written by the AU may serve useful based on the definition of policies in this thesis. Policies, strategies, reports, records and official statements from the organisation's official web page were therefore sourced. As the author of the primary data, any policy published under their name is treated as a representation of AU's view, regardless of which commissions published them. The organisation serves as one of many actors that form the SRHR discourse.

After a detailed assessment, three main documents addressing SRHR is selected as primary data and serves as the basis for my analysis:

- Continental Policy Framework on Sexual and Reproductive Health and Rights (AU, 2006) (hereafter the CPF)
- Maputo Plan of Action 2007-2010/ 2015, (AU, 2007) (MPoA-2007)
- Maputo Plan of Action 2016-2030, (AU, 2016) (MPoA-2016)

Two documents support these to assist in revealing the problem representations and strengthen the credibility of the findings:

- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (AU, 2003), (Maputo Protocol below)
- Strategy for Gender Equality & Women's Empowerment for 2018-2028, (AU 2019), (GEWE below)

The documents are tightly linked as they refer and build upon each other. This is known as inter-textuality since it enables a focus on the social and historical context the documents are situated in (Bryman, 2012). The Maputo Protocol serves as a basis by setting the scene for SRHR in the context of AU. Focus is primarily on the sections referring to SRHR and women with disabilities, meaning that the full content of the document is not analysed. The CPF moreover serves as a key policy for guiding AU member states policy formulation on SRHR. It builds on the prior mentioned ICPD, MDGs and the Maputo Protocol by solely addressing the issues of SRHR in an African context. The MPoA-2007 and MPoA-2016 are vital as they serve as operationalisation documents of the CPF and the Maputo Protocol. The reason for including both action plans is to reflect a time perspective that can suggest shifts within the SRHR discourse. Parts of the GEWE assist in highlighting the broader SRHR discourse and how women with disabilities are constituted. The analytical strategies mainly found in Q2 help in interpreting these documents.

Prior literature is reviewed and synthesised as secondary data to support and strengthen the credibility of the analysis (Bowen, 2009). Peer-reviewed and cited studies, mainly conducted in LMIC after 2000, retrieved from online library catalogues are therefore included. Henceforth, the macro-perspective is grounded in empirical examples from academic literature regarding persons with disabilities relationship to SRHR to consider what effects policies might have and what the lived experiences are, inspired by Q5 in the WPR approach. However, the limitation of using secondary sources is the inability to account for the studies purposes and research design (Bryman, 2012). To conclude, there is a possibility that different themes would have emerged if other data had been chosen, and the text selection is a highly interpretive exercise, which may be viewed as biased selectivity (Bacchi, 2009; Borowska-Beszta, 2017). It is minimised through reflexivity (section 4.5).

4.4. Analysis plan

The analysis carries a deductive approach as it draws from discourse analysis techniques found in Q1-Q2 and Q4-Q5 presented in 4.2.1. The documents are operated on simultaneously to consider what the dominant SRHR discourse is. This is presented in a synthesised manner. Specifications to the individual documents are therefore included since their time of publication may reflect a change in the discourse. Based on multiple readings, central themes emerge from the data, primarily from on the strategic focus, priority actions and indicators for measurements since "what we propose to do about something indicates what we think needs to change and hence what we think the 'problem' is" (Bacchi and Goodwin, 2016:16).

According to Bacchi (2009), there are often multiple and contradicting problem representations within a policy. Recurring topics, use and inconsistency of terminology are observed in the data since it plays a vital role in interpreting what discursive practices SRHR rest upon. This shapes SRHR as a specific type of 'problem', detecting how it is thought about. Linkages between key concepts are also noted to analyse how women with disabilities are constituted as particular kinds of subjects through the problem representation of SRHR. The analysis is nevertheless limited to only investigating four representations regarding SRHR to shed light on how this group is constituted (see chapter 6).

Since the study prioritises utilising several but not all six WPR questions, the analysis does not separately display the questions and findings. Similarly to a holistic analysis (see Yin, 2009), it is systematic in a way that presents a cohesive analysis. It integrates notations like ‘(Q2)’ and ‘(Q4)’ at the end of some sentences to indicate references to a specific question (Bacchi, 2009).

4.5 Reflexive practice

Although the nature of this research does not incorporate subject-participants, which requests its own sets of ethical guidelines, positionality and reflexivity are vital. To start with, I take into account and recognise the discursive field I am within, which is that of ‘international development’. There are multiple ways to go about ‘development’, especially from a critical approach (Veltmeyer and Bowles, 2018). I am also considerate that I am balancing between human rights and health discourses, which to some extent are viewed as distinguished from each other (Nixon and Forman, 2008). Efforts have been made to combine their ethics (Mann, 1997; Gostin, 2001). In addition, it is undeniable that the critical policy analysis approach I undertake is a marginal position within the broader policy analysis discourse. Hence, the practicality of this approach could be questioned, as it is not likely it will create an immediate shift in policy analysis. It nonetheless encourages us to examine how policies, designed by us, shapes peoples understanding and experiences of the world (Goodwin, 2011:178).

Moreover, I face challenges as a white, non-disabled, female researcher based in Western academics to explore and question policies in a context I am not entirely a part of. This might create bias in regards to the themes brought forward and analysed (Borowska-Beszta, 2017). However, simply proclaiming self-position is inadequate while affirming identity in research can be criticised (Simpson, 2002:29). Thus, by careful consideration of what perspectives I incline to bring forward, I carry a reflexive practice throughout my whole research process. However, Haraway (1988) observes that it is not identity per se that produces science, and she offers a critical view by proposing partial objectivity.

4.6 Limitations of the study

The WPR approach is not a common policy analysis method, and little attention has been given to policies in an African context using this perspective, especially on the topic of SRHR. This restricts reference to prior studies set in similar contexts. It is also a limited data selection and not representative of all AU policies; henceforth, it does not seek to generalise the findings (Bryman, 2012).

Due to data limitations and time restrictions, the study does not include cross-national SRHR policies from different AU member states nor use all six questions in the WPR approach but the policies have high authenticity and credibility based on the producer, source and purpose (Bryman, 2012:544). However, there are limitations in its representativeness as it originates from the AU, which is only one actor that may shape the knowledge of SRHR and the surrounding discourse. Key expert interviews and media sources are not included, which could have been an insightful aspect and might have yielded comments on how the 'problem' had been defended or could be resisted (Bacchi and Goodwin, 2016:110). It is excluded due to lack of access, time constraints and beyond the scope of this study.

Lastly, the four themes identified and analysed are based on the researcher's particular understanding and interpretation of the data. This implies interpretational differences, and there is a possibility that other themes would have emerged if other sources had been consulted (Creswell and Poth, 2017:483).

5. Contextual background of policies in the AU

This chapter demonstrates inter-textuality and how the policies are nested within each other (Bacchi, 2009). It is intentionally presented before the analysis to upset the assumption about a 'natural' policy-evolution, inspired by Q3. A descriptive formation of the broader SRHR surrounding within a macro AU context is therefore provided to propose how certain understandings of SRHR become dominant and provide reasoning for my analysis in the following chapter.

5.1. The ICPD aftermath

The AU member states agreed and adopted the Maputo Protocol in 2003. It has been described as progressive in many aspects, especially its reference to abortion and GBV against women, including harmful practices such as FGM and child marriage (Mohamed, 2014). Reproductive rights and SRH, primary related to fertility and HIV/AIDS, is included and medical abortion is authorised in some instances (AU, 2003:15). It was reported to be the first time abortion, resulted from incest or rape or when endangering the woman's life, was explicitly stated in international law (Taylor & Francis, 2003).

In 2006, the same year as the CPF was endorsed, the UNCRPD was affirmed. The African Decade of Persons with Disabilities, initiated by the AUs predecessor, was already in full swing lasting between 1999-2009 and prolonged by AU in 2012, lasting between 2010-2019 (AUC, 2013). As a priority action towards AU member states, it was suggested to address the needs of women with disabilities during the AUs Unions Women's Decade (2010-2020) and explicit references were made towards combatting sexual violence and ensuring SRH services (ibid:12-13).

5.2 Beginning of the African Women's Decade

The AU adopted the resolution on Maternal Mortality in 2008, and the issue was declared a "continental emergency" (ACHPR, 2008). The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), with the slogan 'Africa cares: No woman should die while giving life', was subsequently launched in 2009 and derived from the CPF (AUC, n.d.). The African Women's Decade 2010-2020 was declared by AU (2010) while UN declared a ban on FGM in 2012 (UNGA, 2013). The MPoA-2007 was, in turn, the operationalised and costed plan of action to implement the CPF. It ran between 2007-2010 and extended to 2015. A review of its success and additional Maternal, Newborn & Child Health (MNCH) status reports was undertaken by AU and its partners, casting increased attention to Reproductive, Maternal, Newborn, Child And Adolescent Health (RMNCAH) (AU, 2015; WHO, 2015). Noteworthy is that ACHPR General Comment 2 on Article 14.1 (1)(a), (b), (c) and (f) and Article 14.2 (a) and (c) was added in 2014 to the Maputo Protocol (ACHPR, 2014). These comments relate particularly to fertility, abortion and CSE. Simultaneously, the ICPD program of action was formally to end with the MDGs. However, pledges are made to continue its implementation as it is argued to be in line with the SDGs (ECOSOC, 2019).

5.3 Post-2015

Linkages to the SDGs are visible in the long-term goals of the AU's Agenda 2063: "The Africa We Want" (AU, n.d.), of which the MPoA-2015 is part of (AU, 2016). The inclusion of women and youth are stated as key components of this development. The publishing of the GEWE for 2018-2028 was moreover in line with the declaration of Financial and Economic Inclusion as the theme for African Women's Decade 2020-2030. In 2018 the AU moreover adopted a regional version of the UNCRPD, the

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa. Article 27 explicitly relates to women with disabilities. It includes dimensions of SRHR such as GBV and "the right to retain and control their fertility, and are not sterilized without their consent" (AU, 2018:19). Simultaneously, conservative power spread out. The Mexico City Policy, commonly known as the global gag rule and mainly led by the US Government, was argued to halt progress in sexual and reproductive rights, gender equality and the rights of sexual and gender minorities (The Lancet, 2019).

When ICDP furthermore marked its 25th anniversary in 2019 the UNFPA (2019) stated that behind statistics lies people, and barriers still exist for persons with disabilities. The same year, an evaluation was undertaken to promote the CARMMA's 10th anniversary. It revealed that AU member states that took part in the campaign had improved their MNCAH indicators and announces to re-strengthen the campaign for 2021-2030 (AUC, 2020). Furthermore, in November 2020, a technical advisory group on RMNCAH was launched. It has the duty to advise WHO AFRO on policies and strategies related to SRHR, Maternal, Newborn, Child, and Adolescents' health (WHO, 2020).

Finally, a bill on SRH was presented by the East African Commission in 2017 but withdrawn in February 2021 based on contesting religious, traditional and cultural views. Controversies regarding the understanding of what "abortion services" entails and not aligning with domestic laws and the absence of reproductive health rights of adolescents, young people, the elderly and male involvement are proclaimed as grounds for its withdrawal (EAC, 2021).

6. Analysis of findings

This chapter begins by problematising SRHR and reflects upon what thoughts dominate the current discourse. The position and constitution of women with disabilities are thereafter addressed through the problematisation of contraception, socio-environmental conditions, GBV and information, education and communication (ICE). The findings are analysed in an integrated WPR approach by identifying grounding assumptions within the chosen SRHR problem representations (Q1-Q2) and reflect on silences and effects due to these representations (Q4- Q5).

6.1 Representations of 'SRHR'

A WPR analysis begins with proposals in policies; in this thesis, that of "promoting sexual and reproductive health and rights in Africa" (AU, 2006:40). Based on the call for action, it reveals that the 'problem' of SRHR is thought about in the general term of "unnecessary death of women and children on the continent" due to lack of health sector engagement (ibid:5) (Q1). Challenges in the context of Africa are presented in terms of teenage pregnancy and unintended pregnancies; high infant and child mortality rates; high maternal mortality and morbidity, unacceptably high spread of HIV, sexual and GBV and insufficient health budget allocations. The content, or 'solutions', of the CPF, MPoA-2007 and MPoA-2016 reflects what is being prioritised. It discloses how these 'problems' are thought about and what meaning they are given.

A closer look reveals that these challenges of SRHR are vague with the essential details to deliver 'sexual health' and 'sexual rights'. As the CPF draws from the ICPD, the definitions of 'reproductive health' and 'reproductive rights' are retrieved from this. The CPF adds sexual health to be included in its definition, admitting it refers to more than health care and by including "enhancement of life and personal relationships, not merely counselling and care related to reproduction and sexually transmitted diseases" (AU, 2006:10). Yet, the MPoA-2016 excludes this dimension of sexual health in its glossary. One could instead claim sexual health to be constructed in terms of reproductive rights, also stemming from the ICPD, stating commitments to "meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" (AU, 2006:10; AU, 2016:9). This resembles the notion of CSE.

Sexual health may thus be interpreted as a vital dimension of sexuality education. The MPoA-2016 account for this by referring to a previously agreed AU meeting in 2015. It specifies CSE as "age-appropriate and culturally sensitive comprehensive education on sexual and reproductive health for young people that involves parents and communities" (AU, 2016:9). Apart from this, the CPF proposes to "introduce and/or strengthen sexuality education in and out-of-school activities" (AU, 2006:36) by assuring that sexuality education manuals are in place. No details on how or what it could include are stated. This derives from the documents established to guide member states national policy formulations of SRHR (AU, 2006:8). To some extent, this signals how sexuality in this context is partly embedded in a culture of secrecy, taboos and resistance to openly discuss the subject (Hanass-Hancock et al., 2018). It is also seen in Waldman and Stevens (2015:98) reference to "safe topics".

The underlying assumption is somewhat visible under capacity building aimed at "Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing" (AU, 2007:12), which promotes countries to have an "Information, Education, and Communication (IEC) /Behavioural Change Communication (BCC) strategies that promote abstinence and condom use" (ibid). Resistance to condom use has been associated with promiscuity (Biersch, 2015: 43), suggesting the meaning behind this statement (Q2). In addition, the "percentage of young people with knowledge about both abstinence and condom use" and "teenage pregnancy rate" is used as other indicators for two strategic actions under service delivery (AU, 2007:12). Condom distribution and use are otherwise referred to in terms of HIV/AIDS (ibid: 8). To some extent, this signals two vital and competing views for how SRHR is shaped. The references to abstinence and condom use could also be governed according to cultural and religious reasoning, which aligns with Klugman (2000:157) analysis of ICPD and FWCW (Q2). For example, the need to sensitise relevant authorities and mobilise political will is proposed to translate ICPD commitments to national policies and regulations (CPF, 2006:32).

One priority action for youths SRHR is to "Empower young women to say NO" (CPF, 2006:36). It might relate to how a woman's "personal virtue (her virginity)" increases the bride price (Eniola and Aremo, 2020:28), albeit highlighting that society should "view bride price as a mere cultural observation without any ulterior motive to subjugate the woman" (33). However, with this in mind, a built-in implication for who is responsible for unintended pregnancy and STI/HIV is suggested. The attribution of responsibility is placed on young women and creates an understanding that those women who did not say "no" are to blame, which may cause further harm for these women (Q5). Due to the inter-textuality of data, it can be assumed that these policy documents rests upon underlying Christian, Muslim and 'traditional African' values, which also mystifies the biopower relationship between governments and youth (Q2, Q4). This is because youths are likely to be governed into particular kinds of cultural and religious subjects based on these moral underpinnings of promiscuity, representing SRHR as something for youths to be cautious of. Yet, the encouragement of condom use demonstrates how an HIV/ AIDS discourse exists within the problematisation of SRHR in this context (Hopkins and Collins, 2017).

Producing particular subjects by representing SRHR in a certain way suggests a notion of population control. The MPoA-2016 intends to influence and accelerate "Africa's structural transformation in the next fifty years" (AU, 2016:13). It envisages a "people-driven development, especially relying on the potential offered by its women and youth" (ibid:14). Similarly, it states, "The implementation of this Plan of Action will bring about improvements in the health status of women, children, adolescents and young people and hence greater family savings and stronger economies in Africa" (AU, 2016:27). The problematisation of 'SRHR' is hence produced in terms of biopower as it views African society as an entire body along the lines of societal control. The GEWE demonstrates this knowledge practice by stating Agenda 2063 as "re-writing the African narrative, and Africa claiming its rightful place in global affairs" (AU, 2019:47). Reference to Agenda 2063 and "The Africa We Want" (AU, 2016:20) further supports notions of biopower underpinnings as 'SRHR' is represented in terms of issues that ought to be discussed in the context of Africa, supporting the progress of "Africa's structural transformation" (Q2).

6.1.1 Discursive differences

The CPF explicitly refers back to ICPD and the Maputo Protocol, reflecting how the documents are nested, as previously stated. Yet, it also reflects differences and what representation of SRHR dominates. For example, the MPoA-2016 refers to the Maputo Protocol to "enshrines sexual reproductive health and reproductive rights (SRH&RR) of women and men as a human right" (AU, 2016:15). The CPF declaration expresses concern that adolescents and youth carries a large burden of STI and HIV, sexual abuse and "other life-threatening challenges to their SRH&R" (AU, 2006:24). Similarly, it should be "Ensure[d] that RH & R policies and actions follow a life-course approach" (ibid) but also "advocate for the inclusion of sexual and reproductive health and rights in all agreements entered into for socioeconomic development" (ibid:25). Here, we recognise multiple discursive distinctions within SRHR terminology, depending on what actions it relates to and how to go about it.

The practices of incorporating 'SRH&RR', especially in the MPoA-2016, could be interpreted as including a more explicit rights-based approach (Q2). Here 'reproductive rights' carries a specific understanding. The operation plan deems it "a precondition for and an outcome indicator of all aspects of sustainable development" (AU, 2016:20). It considers the SDGs achievable when the preventable maternal, newborn, child and adolescent morbidity and mortality is absent (Q1) (ibid). As the latest document was reviewed in line with the SDGs, the rights-centred practice might have assumed a dominant position as something of particular relevance to underline in the policy (Q3). This demonstrates how knowledge practices are shaped across time, place and political space.

The distinction of stating 'SRHR' in terms of 'SRH&RR', thereby omitting sexual rights, could be interpreted in light of other rights as the prior literature show (Brown et al, 2019; Ferguson et al., 2019). For example, the right to live free from violence and discrimination is acknowledged under the strategic action to "Ensure access to services that address gender-based violence including management of sexual abuse, emergency contraception…" (AU, 2007: 9). On the other hand, this terminology of SRH&RR can be interpreted as a discursive practice. It appears to be a silencing effect towards contested topics by limiting how it is written about and shrinking its space (Q5).

Therefore, it is possible to detect an adversary to state or claim the dimensions of CSE or GBV as sexual rights. This could indicate a further deviation within the African SRHR discourse and affect in what ways SRHR can be expressed. When sexual rights fail to take place in the dominant knowledge practice of SRHR, it might be conveyed as 'other' knowledge, meaning something that exists in the margins or has been silenced. This is strengthened by Coultas et al. (2020), findings which reveal that CSE is perceived as something foreign.

The MPoA-2016 expands the discursive practice of SRHR by incorporating 'RMNACH' in its strategic focuses and priority interventions, such as "Improve Political Commitment, leadership and Governance for RMNACH" and "Institute health legislation in support of RMNCAH" (AU, 2016:32-33). This signals its presence in both health and rights aspects. RMNACH could be viewed in the lines of impacting power relations since the latest operational plans were reviewed and revised based on the previous document (see section 5.2). A different development of SRHR could have taken place if the operational plan had been revised in another direction (Q3). However, RMNACH takes a more predominant role in the latest operational plan, and is not present in the prior CPF or the MPoA-2007. This proposes how power shapes the problematising of SRHR in accordance with the dominant discourse of SRHR. Noteworthy is that RMNACH appears to be shaped by a particular knowledge practice of SRHR; as something relating to reproductive, maternal, newborn, child, and adolescent health. SRHR continues to be represented as and emphasised in terms of health-related elements instead of a rights-based approach (Van eerdewijk et al., 2018:56). The tension between terminologies moreover reflects and contributes to the representation of SRHR as an issue of 'unnecessary death of women and children' in the AU policies. But as the section started, SRHR contains additional aspects and these problematisations might have effects for women with disabilities.

6.2 Contraception

The decision-making power of one's body and sexuality, determining when and whether to bear children and accessing essential SRH information and services are perceived as core dimensions of SRHR in the ICPD (UN, 1995a). However, the MPoA states that "About 58% of women who want to avoid pregnancy are not using any effective methods of contraception and account for a disproportionate 93% of unintended pregnancies" (AU, 2016:29). Expanding and encouraging contraception uptake is, for example, necessary to reduce maternal mortality and morbidity (AU, 2006:34, AU, 2016:36). Therefore, a problem of 'contraception' is presented and appears to be given the value of life-saving activities (Q1, Q2).

However, women may need consent from a partner or a third party to access these (Akaba et al, 2016; Bahamondes and Peloggia, 2019). Sometimes contraception use is socially sanctioned, in the form of traditional and patriarchal observations, which govern their choice. In some instances, women are even forced to lie and might be subjugated to violence, or threat thereof, for using family planning methods (Kibira et al., 2020). So, while acknowledging women's right to decision-making, it seems like it does not address how women may be subjected to unequal power and gender structures in intimate relationships or societal structures, limiting their access to or usage of contraception. Representing contraception as solely a decision of women appears to place the burden of using contraception, or not, on women as an individual responsibility.

However, "Develop and implement a programme that ensures partnership with, support from and inclusion of men in SRHR services" (MPoA, 2007:9) is referenced in the first operational plan. It is measured with the percentage of "men with favourable attitude to SRHR (FP, assisted delivery)"(ibid). This is excluded from the latest operational plan. Yet, the rationale recognises "In Africa, family planning is still viewed as the responsibility of women, with programmes targeting women whilst over-looking the role of men" (AU, 2016:20). The priority intervention to "promote community involvement and participation in RMNCAH, with special focus on male involvement" (AU, 2016:34) seems like an effort to approach the situation of current power relations. It aligns with the observations by Akaba et al. (2016:89) that men tend to dictate spacing between children, family size and contraception choice. The only proposed indicator measures "percent of men accompanying spouses for RMNCAH services" (AU, 2016:34).

However, there is a noticeable weakening of male involvement in SRHR considering the CPF states to "promote male involvement in RH programmes" as a strategic focus which included actions such as available SRH service for men and strengthening men's knowledge of SRHR issues (AU, 2006: 39). Therefore, based on the latest MPoA-2016, men's involvement, engagement and responsibility appear to be silent in the SRHR discourse. This contradicts what the studies find, positioning men as key decision-makers of contraception use (Akaba, 2016; Ogunjuyigbe et al., 2009; Bietsch, 2015). SRHR and contraception are primarily represented as an issue that relates to them in terms of their relation to women, not to them individually or for their own use (Q4).

Therefore, contraception continues to be represented as ‘women’s issue’ in the policies of the AU. Challenging patriarchal hierarchies has nevertheless been deemed necessary to complement policy initiatives (Van eerdewijk et al., 2018). Silencing men’s involvement consequently mystifies women’s lack of negotiation-power regarding contraception. So, even though women are constituted as ‘decision-makers’ in the policies, underlying social structures that potentially hinder women from exercising this reproductive right are not challenged. Contradictory, this might undermine women’s position as ‘decision-makers’ and their autonomy since the hierarchal men/women narrative continues to be mystified. Subsequently, it appears that it silences men’s influence on women’s contraception use (Q4, Q5).

Although, this presumed representation of contraception as encouraged to women does not stretch out women with disabilities. They are met with an interrogation about their sexual life, sculled for requesting contraception, recommended abortion and their desire for childbearing is questioned (Mavuso and Maharaj, 2015, Peta, 2017). Instead, there is a “pretext that they should not become pregnant and give birth owing to their disability” (Ahumuza et al., 2014, p. 5) which underpins how this group is understood (Q2). Along the lines of the social model of disability (Oliver, 2013), there is a built-in stigmatisation of women with disabilities and an attribution of responsibility that they are the ‘problem’, which draws attention away from the social factors that hinders their access to contraception. Representing contraception in terms of ‘decision-making’ is therefore likely to reinforce existing power hierarchies. The lived effects signals that although women with disabilities have desires of childbirth, they continue to be (re)produced as asexual in society, not in need of contraception, opposite to the ‘able women’.

6.3 Gender-based violence (GBV)

As previously mentioned, women may face violence if their partners find out about their contraception use. GBV is a significant issue that is raised in all documents (Q1). For example, the CPF presents “While sexual and domestic violence is widespread in most African countries, the phenomenon is still poorly reported due to socio-cultural reasons and to the legal vacuum surrounding this issue." (AU, 2006:16) and acknowledges that it is tolerated in some socio-cultural settings (ibid:38). This recognises that underlying patriarchal and cultural values impact how GBV is thought about (Q2). It also presumes a hierarchical binary between women and men. Although, it admits to some extent that unequal sexual power relations exist between these positions. Under the strategic focus to "Ensure gender equality, empowerment and human rights" (AU, 2016:33), the indicator "ever partnered women and girls (aged 15-49) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 month" is suggested. GBV is also closely tied with harmful traditions such as FGM (AU, 2007:15; AU, 2016:34). However, the representation of GBV suggests a narrow interpretation as it explicitly states, "subjected to physical and/or sexual violence" even though the Maputo Protocol recognises all forms of violence for women and threats of violence. Other dimensions of GBV are thus absent in the primary data, which portrays a limited representation of the issue and shapes how GBV continues to be thought about (Q4).

The position of GBV has nevertheless shifted in the latest operational plan, taking a more prominent position. The legal aspects reflect the prosecution of GBV cases and programmes dealing with GBV are stated under the strategic focus of health legislation (AU, 2016:33). Prevalence of GBV and the proportion of prosecution alongside the number of countries with GBV programmes are stated as indicators (ibid). This is likely to re-produce the perspective to "Empower women to bring cases of GBV into the open and to the court system" (AU, 2006:38,) placing the responsibility on them (Q5). What is noteworthy is that complementing and supportive health aspects to GBV are missing. Collaborative efforts with other stakeholders stated as "Incorporate health management of GBV in the training curricula of health workers and providers of legal services" (AU, 2007:7) is excluded and the issue is mainly represented along the lines of a rights centred approach (Q2).

Although the CPF (2006:38) problematised the legal aspects of GBV, it also includes counselling services such as detecting cases of abuse, developing and distributing guidelines dealing with GBV in its action points and indicators. Therefore, the legislative positioning of GBV continues to be prevalent in the revised MPoA-2016, while interventions from other sectors appear to be missing. Van eerdewijk et al.

(2018:40) observes that not all women are exposed to GBV in the same way and have various needs and challenges as a consequence. This could be interpreted under ensuring GBV service such as "management of sexual abuse, emergency contraception and HIV post-exposure prophylaxis and STI treatment in an integrated and co-ordinated manner" (AU, 2007:9). This is however excluded from the latest MPoA-2016. When options like this are closed off for social intervention, it limits how GBV is understood. This representation could have real effects for social groups exposed to vulnerable situations (Q5). In addition, the rights/ health dichotomy mystifies the relationship between women and men and fails to problematise why GBV is prevalent in the first place (Q4).

6.3.3 GBV in relation to women with disabilities

The CPF policy statement declares, "women should be empowered to decry domestic violence and young girls should be enabled to grow up with self-esteem" (CPF, 2006:22). Approaching the issue of GBV from a legal aspect appear to represent it as a 'women's problem' and does not target the underlying patriarchal structures or causes of the 'problem', such as men's responsibility in the issue (Q2, Q4). To some extent, the problematisation is shifted. It is problematised later as "Change of attitudes remains key to eliminating GBV yet programmes tend to be reactive rather than preventive" (AU, 2019:35) which signals a discursive practice in how the issue is represented. However, the examples brought forward of social-cultural values of GBV are of women justifying domestic abuse on certain grounds or accepting wife-beating as a normal practice (ibid; Van eerdewijk et al.,2018:40). This signals an attribution of responsibility within the problematisation of GBV, and women are more likely to be harmed by this representation (Q5). It is damaging because it represents it as their obligation to change while simultaneously constituting them as victims of GBV. In addition, without dwelling in discourse as linguistics, it is noteworthy that GBV is portrayed as something women "experience" as opposed to "exposed to".

Women living with disabilities are moreover explicitly recognised as a target group exposed to violence and abuse (AU, 2019:15). The Maputo Protocol refers specifically to women with disabilities under Article 23 stating member states to "Ensure the right of women with disabilities to freedom from violence, including sexual abuse, discrimination based on disability and the right to be treated with dignity" (Maputo Protocol, 2003:18)". Yet, there are few references to the specific need of women with disabilities in the primary data. It seems like their SRHR needs are centred on their disability, portrayed as a vulnerability to GBV(Q2).

Notwithstanding the lived reality women with disabilities face in regards to rape, forced sterilisation and inaccessible contraception (Burke et al., 2017; Peta, 2017), the academic focus on abuse and discrimination (Carew et al., 2017) contributes to making the subject position of 'vulnerable' available for women with disabilities within the SRHR discourse. It is therefore implied that the group is primarily governed and constituted as SRHR subjects through the problematisation of GBV. Yet, while women with disabilities are made to 'vulnerable subjects' through the representation of GBV, it reinforces a status quo since supporting reforms or actions targeted especially to this group is left out. This may have deleterious effects such as shortcomings in SRH care, inability to report abuse or claim legal compensation, which the policies present as 'solutions' (Q5). Therefore, the understanding of women with disabilities may fail to shift attention from their positions to the disabling factors within the suggested actions to mitigate GBV. In addition, it is assumed to have harmful effects on individuals' self-perception and relationships with others as it reinforces a notion of women with disabilities as either asexual or 'vulnerable' as victims of sexual abuse.

6.6 Socio-environmental conditions: disabling structures

The "crosscutting issue … rural-urban service delivery equity" is recognised in the data (AU, 2007:5). It is thought about in terms of increased investment in human resources, with "particular attention to rural and hard to reach areas and countries aiming at achieving excellence in human resources capacity development" (AU, 2016:24). The problem representation of socio-environmental factors in the shape of geographical inaccessibility and inadequate health care staff is therefore recognised (Q1). Priority interventions include "Invest in poor and marginalized and empower and address their RMNCAH challenges" and "Strengthen primary health care systems by linking comprehensive RMNCAH, HIV&AIDS, Malaria/TB services especially at all levels of the health system" (AU, 2016:35-36). This brings forward assumptions that a person with low economic capacity has negative SRHR outcomes(Q2). Adding to this is Trani et al. (2011) observations that poverty and low socioeconomic status is a larger obstacle than disability in accessing SRH services in Sierra Leone. The policies attention of SDH seems to recognise this (Exworthy, 2008; Toure et al., 2012). Nampewo (2017:124) moreover notes that women with disabilities tend to live in remote rural areas with low quality and limited access to health facilities compared to urban areas. Representing SRHR along the lines of rural development, problematised as geographical inaccessibility may signal how SHRH is thought to benefit rural living women with disabilities (Q5).

Socio-environmental conditions are represented further along the lines of "Provide services for the SRH needs of all persons including vulnerable groups and mobile populations especially migrant women, IDPs and those in conflict situations" (AU, 2007:9). Here, women with disabilities could be recognised since they might be constituted within 'vulnerable groups', falling under 'poor and marginalized' mentioned above (AU, 2016:35; Braveman and Gruskin, 2003). The notion of 'vulnerable' is nevertheless contested and highly contextual, which is noticeable as migrants and displaced persons are mentioned as an example, not persons with disabilities. Chinyama et al. (2018:298) view vulnerability as an "experience arising from how some groups are positioned by social attitudes and structures that disadvantage them". Based on the stigma and discrimination women with disabilities encounter in this context (McKenzie, 2013; Casebolt, 2020) it is possible to assume they are categorised as this (Q2). Although, one should not accept this as given since Shakespear (2014:219 in Campbell, 2017:8) also note that the concept of 'vulnerability' has other functions such as "deny people with intellectual disabilities the right to make choices, take risks and live independently".

Persons with disabilities are nevertheless stated under "Investing in SRH needs of adolescents, youth and other vulnerable marginalized populations" (AU, 2016:23). This could recognise the disabling social structures limiting women with disabilities to access these services (Hameed et al., 2020). Although, the group is not included in the indicator to measure "most-at-risk populations (including refugees and other displaced with RMNCAH and HIV services" (AU, 2016:35). It also states that "vulnerable and marginalized groups/ populations" is defined within the national context and policies (ibid, p. 9)(Q2). This is in line with the argument that women with disabilities are not intrinsically rendered ‘vulnerable’ and what meaning ‘vulnerability’ is given to it depends on the particular situation (Lang et al., 2011). Because of this, the SRH needs and services for “vulnerable and margianlized groups/ populations” are at risk to be subjected to contextual power relations since it may create dividing practices; placing the needs and priorities of these social groups in opposition to each other. So, there is an assumption that SRHR needs are not homogenous and have to be applied differently depending on social groups (Q2). Yet differences within groups are not expanded on; limiting which groups can be considered.

Furthermore, an urban-rural binary is suggested and could be interpreted to hold an implied hierarchy (AU, 2007:3). It assumes that rural services have been given less attention and resources (CPF, 2006:17), shaping the understanding and problematisation of issues related to SRHR as primarily a rural ‘problem’ (Q2). The attention to strengthening and building community-based SRHR services could be interpreted as support for this view alongside the focus to “develop and implement behaviour change communication strategy for community mobilisation and education on health promotion and utilisation of integrated SRH” (MPoA, 2007:10). It signals how the policies set urban-rural groups in opposition to each other and encourage certain behaviours, primarily from the rural living population (Q5). There appears to be a built-in assumption of rural populations as responsible for issues related to SRHR, which distracts attention away from the inadequate and disabling public health facilities to start with, both in urban and rural locations (Ahumuza et al., 2014; Peta, 2017; Rugoho and Maphosa, 2017). Instead, it risks reinforcing existing power structures since government responses such as removing user fees and investments in medical infrastructure (MPoA, 2016:43), recommended here, are portrayed as generous. The systematic socio-environmental barriers rural and urban living women with disabilities face seems to be silenced (Q4).

However, strengthening the referral system for RMNCAH is suggested (MPoA, 2016:36), which could oppose the silence. It is noted that women with disabilities tend to be referred more often to tertiary facilities by health care workers due to fear of complications (Trani et al., 2011). When SRHR is problematised in terms of infrastructural investments, it could therefore benefit women with disabilities (Q5).

However, this may include additional travelling time and cause hidden costs, having to pay for an assistant or being accompanied there (ibid; Rugoho and Maphosa, 2017). This indicates that the perception of disability may affect what care they receive, while inaccessible facilities and discrimination within the public health care system simultaneously occur (Mavuso and Maharaj, 2015:84), which risks reproducing existing power structures (Q5). Apart from "sensitising health personnel to deal with people living with HIV/AIDS in a non-judgmental way" (AU, 2006:36), references to reshaping power relations echo with its absence. The lack of attention and resources targeting health care providers' societal perceptions of persons with disabilities signals the group's hierarchy within the SRHR discourse.

Health care workers are nevertheless positioned as significant contributors and actors within the SRHR discourse in the MPoA-2007. 'Solutions' such as training healthcare providers in family planning services, including youth-friendly health services in their training curriculum and prevention and management of unsafe abort and comprehensive safe abortion care, where the law allows, is brought forward (AU, 2007:12-14). However, their position gains less attention in the latest operational plan. They are recognised in the strategic action to "Improve recruitment, development and training, motivation and retention of the health workforce" is stated (AU, 2016: 38). Yet, the only indicator is the number of health workers, not the 'quality'. It gives no suggestions on what the "development, training and motivation" (ibid) could mean. Their compromised presence in the latest MPoA-2016 suggests a change in how they are thought about which is surprising as Tumwine et al. (2020:5) note that health care practitioners often influence how services are implemented and their active "knowledge seeking behaviour" impacts their attitudes to SRHR practices. In addition, the perception, not only experience, of health providers' attitudes is stated as a barrier for youth with disabilities in Senegal (Burke et al., 2017:50) which signals how subjectification effects modify behaviours, for the subjugated group itself. Therefore, when health care providers are represented along the lines of 'numbers' it creates a discursive effect since it does not present a change but rather reinforces a status quo in the development and training of health care professionals (Q5).

So, when SRHR is represented in order to offer options for social interventions, with attention to socio-environmental situatedness, women with disabilities could be constituted as rural living women. This representation might benefit them as it upsets a notion about disability automatically translated as ‘vulnerability’. However, the representation of health care workers may have harmful effects since it fails to problematise the disabling social and physical structures that reinforce existing power relations (Q5).

6.7 Information, education and communication (IEC)

The need for public information, education and communication (IEC) about SRHR is present in all documents and conveyed in terms of “access to SRH services, information and education” (AU, 2016:33) or “number of countries with IEC strategies for parent education for young people” (AU, 2007:12). It is used to convey public health messages to a population, which could be viewed as a sign of biopower. This is because the problematisation of IEC governs us, rather than the policy in itself. The CPF refers to relevant SRHR information and proposes to “introduce and/or strengthen sexuality education in and out-of-school activities” (AU, 2006:36) by assuring that sexuality education manuals are in place. The Maputo Protocol had previously stated that member states should take measures to “Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas” (Maputo Protocol, 2003:18). This plays into the socio-environmental conditions women with disabilities face, as highlighted in the previous section. The AUs General Comment 2 strengthens this notion by stating that information on family planning/contraception should contain accessible language and form to all women, including those with disabilities (ACHPR, 2014:10). This signals a discursive shift to represent accessibility in terms of disability.

The perception of service delivery in regard to IEC in the MPoA-2007 can moreover be understood as “Provide appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services” (AU, 2007:9) and “Develop gender and culture appropriate information to enhance FP knowledge in the target populations” (ibid:11). On a short note, ‘gender and culture appropriate’ information could be questioned as contested concepts. There might be competing political and social views of how these concepts should be interpreted in national practice (Q2). For example, culture and religion have previously been said to impact how SRHR can be thought about, and the discussion on CSE signals that competing knowledge practices govern how SRHR education is understood (Coultas et al., 2020).

Going further, target populations in this document have a general reference. We could interpret women with disabilities to fit within "other marginalized groups" based on the different factors that constitute vulnerability, marginalisation, disadvantaged or disenfranchised social groups as highlighted previously. This is significant since studies show that women with disabilities face significant information and communication barriers within the SRHR system and within society at large (Arulogun et al., 2013; Hameed et al., 2020).

Furthermore, the strategic action to "Improve strategic communication for SRH & RR" (AU, 2016:34) represents efforts to convey IEC to the public. It seeks to establish "effective behavioral change communications and information sharing mechanisms to promote SRH&RR services including initiatives to reduce gender inequality" (ibid). Although the AU's General Comment 2, endorsed in 2014, pays distinctive attention to the inclusion of women with disabilities, the SRHR policies discard the different ways persons with disabilities collect information. No reference is made to ICE in the form of braille, large print, and sign language interpreters, or potentially introduce escorting birth companions, which Peta (2017:17) mean could be both practical and emotional support for women with disabilities since it is not feasible to expect all health care workers to learn sign language (Q5). Disability accessibility appears to be disregarded from when ICE is represented. Instead, it signals how SRHR is governed for women with disabilities. Based on the lived experiences, such as pressure towards sterilisation or recommendations of abortion (Mavuso and Maharaj, 2015; Peta, 2017), the data demonstrates underlying premises that SRHR for women with disabilities is not thought of in terms of sexual agency, motherhood, and childbearing (Q2).

Stressing information-sharing mechanism to promote SRHR may furthermore signal how populations are governed through the problematisation of ICE since member states are encouraged to provide information and services for their population, which encourage a desired behaviour among the population. However, women with disabilities are not perceived as a part of this majority population. ICE in SRHR is not represented as an issue for women with disabilities. Efforts recognising their perception of accessibility are not included in the data as they are not positioned and subjugated in terms of mothers in need of this information but as victims of GBV as previously highlighted (Q5).

The lived experiences nevertheless subscribe to the representation of ICE in regards to women with disabilities. A dividing practice has been noted, which builds on the construction of persons with disabilities as “damaged beings” and should only seek health care in relation to their disability, not SRHR services (Peta, 2017:14). This contrasts with the ‘able-bodied’ woman who is perceived as the recipient of SRHR services. A silent hierarchal able/disabled dichotomy can therefore be assumed (Q2, Q4). It could however be argued that the policies assume a ‘neutral position’ since it does not account for how other social groups are targeted. However, maintaining a ‘neutral’ terminology feeds into the ‘knowledge’ of SRHR needs as homogenous. This representation seems to be (re)produced in the policies, and women with disabilities may instead be harmed by this representation.

However, this interpretation does not seek to shape the understanding of the SRHR needs of women ‘with disabilities’ as something separate from non-disabled women. Instead, it challenges what and whose SRHR needs fit in this problem representation of SRHR, tying back to the initial point of SRHR’s discursive differences.

7 Conclusion

7.1 Summary

This thesis investigates how the current SRHR discourse is represented in three central policies from the AU. With inspiration from Bacchi’s WPR approach, it draws from Foucauldian discourse analysis of subjects, problematisations and power. An adapted version of the approach is applied, focusing on four of the WPR’s six guiding questions. It highlights assumed premises, potential silences and possible effects certain SRHR problematisations may have on women with disabilities.

The findings show that the overall SRHR discourse is mainly represented as ‘maternal and child mortality and morbidity’. It continues to be produced along the lines of population development, encouraging a desired behaviour among the majority to achieve a more vital African continent. Discursive practices subsequently imply a changing terminology of SRHR, which underlines the role of rights, yet creates a further distinction by silencing how sexual health and rights can be thought about. However, multiple ‘problems’ seem to be nested within the problematisation of SRHR, and four representative themes relating to women with disabilities emerge in the analysis.

The policies appear to be constrained regarding contraception because, although contraception is encouraged, it is represented as primarily an individual choice. This fails to take into account the unequal power relationships that exist in society between men and women. The representation could impact women with disabilities, as they are not considered recipients of contraception services in the first place. Instead, they are created and reproduced as ‘vulnerable subjects’ in relation to GBV. This is suggested as the primary subject position available for this group in the SRHR discourse. Yet, the status quo remains. The situation is not assumed to change even though women with disabilities are constituted like this.

Socio-environmental conditions show that SRHR is thought about in lines with rural development, to which women with disabilities could be assumed to belong. However, the limited references to human resources imply limitations in SRHR service delivery and may negatively impact women with disabilities based on societal assumptions. This is supported by the representation of ICE, which suggests knowledge about SRHR is represented as issues for non-disabled persons due to a silent, able/disable dichotomy within the SRHR discourse.

7.2 Future research

Critically distinguishing certain problematisations of women with disabilities in policies from the AU can give rise to a re-representation of SRHR in future policy development. However, the particular interpretation of women with disabilities offered in this thesis should not go uncontested. There are silences in my narrative since only four aspects of SRHR are problematised. This opens a possibility to challenge how other ‘problems’ are understood within the SRHR discourse and question how other social groups are represented in these. Future research may also be inspired to investigate contesting representations and analyse how we can re-imagine SRHR to eliminate harmful effects for women with disabilities. In addition, it is suggested to compare the AU member state's national SRHR policies and investigate if there is a difference in how SRHR is represented and how women with disabilities are understood.

The findings moreover centre on discourse formulations brought forward by political and academic voices. This might reproduce assumptions about this group as we do not stand outside the discourse and silence the voices of women with disabilities. Therefore, it is suggested that future studies include first-hand perspectives from this group to challenge homogenous representations of SRHR in policies, reflecting the political and social surroundings.

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