THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF PEOPLE LIVING WITH DISABILITIES IN NIGERIA:
Factors Influencing Access and Utilisation of Services

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A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in Public Health

by

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Declaration:

Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

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Signature:

56th Master of Public Health/International Course in Health Development (MPH/ICHD)
16 September 2019 – 4 September 2020
KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

September 2020

Organised by:
KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

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Acknowledgement

This study is dedicated to all persons living with disabilities. This was an opportunity to bring to light some of the struggles of people with disabilities in having their sexual and reproductive health and rights (SRH) recognised. This report represents the voice of people with disabilities; a call to rise for their SRH and for change in the society towards all persons living with disabilities.

My sincere gratitude to the Almighty God for His strength and wisdom granted to me to complete this task. Thanks to my family for their love, support, and patience and my heartfelt thanks to my classmates_ 56th ICHD/MPH batch for extensive learning exchange, support, and friendship.

It is also an immense pleasure to acknowledge with the deepest gratitude to the Government of The Netherlands for granting me the Orange Knowledge Programme Scholarship. This opportunity has changed my life and prepared me for a better career ahead in the field of public health. I also would like to express my sincere appreciation to the Royal Tropical Institute, course coordinators, course facilitators and all staff for their excellent teaching, coaching and mentoring efforts throughout the master’s programme.

I would like to also express my sincere gratitude and appreciation to my academic advisor and thesis advisor for their guidance and support throughout the thesis writing process.

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CBR	Community Based Rehabilitation
CBRNE	Community-Based Rehabilitation Network Ethiopia
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CHV	Community Health Volunteers
CRPD	Convention on the Rights of Persons with Disability
DRAC	Disability Rights Advocacy Center
FEDWEN-K	Federation of Deaf Women Empowerment Network in Kenya
FMoH	Federal Ministry of Health
FMWSD	Federal Ministry of Women Affairs and Social Development
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GSDRC	Governance Social Development and Resource Center
JONAPWD	Joint National Association of Persons with Disabilities
LCZ	Leonard Cheshire Zimbabwe
LIDDWA	Lira District Disabled Women Association
LGA	Local Government Area
LMIC	Low-Middle Income Country
HCT	HIV Counselling and Testing
HIV	Human Immune Virus
ICPD	International Conference on Population and Development
ICCPR	International Covenant on Civil and Political Rights
IEC	Information, Communication and Education
I2C	Inspire2Care
IFA	Inclusive Friends Association
PMSEU	Poor, Marginalised, socially excluded and Underserved
PWD	People with Disability
NDWA	Nepal Disabled Women Association
NGO	Non-Governmental Organisation

NHA	Health Accounts
NHA	National Health Act
NPC	National Population Commission
NSRP	Nigerian Stability and Reconciliation Programme
SRHR	Sexual Reproductive Health and Rights
STI	Sexual Transmitted Diseases
USAID	United States Agency for International Development
UHC	Universal Health Coverage
UN	United Nations
UNCRPD	United Nations on Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WBO	World Bank Organisation
WHO	World Health Organization
WWD	Women with Disabilities
YPWD	Young People with Disabilities

Glossary of Key Terms

Key Terms	**Definitions**
Catastrophic Health spending	Catastrophic health expenditure is defined as "out-of-pocket spending for health care that exceeds a certain proportion of a household's income with the consequence that households suffer the burden of disease" (1).
Disability	"Disability is a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors" (2).
Dualist system	A dualist system treats the international laws and treaties as separate and independent. The validity of international law is determined by a rule of domestic law authorising the application of that international norm (3).
Health Disparities	Health disparities are differences that exist among specific populations in achieving optimal health that can be measured by differences in the burden of disease or other adverse health conditions. These particular populations are socially disadvantaged on account of factors such as gender, race or ethnicity, socio-economic status, geographic location, and disability (4).
Impairment	Impairment is defined as "abnormalities of body structure, appearance and organ system and function"(5).
Impoverishment	Impoverishment occurs "when a household that is above the poverty line pre-payment crosses the poverty line after paying (post-payment) for health care, shifting from non-poor to poor" (6)
People with disability	People with disabilities include "those who have longterm physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"(7)
Poverty Line	The poverty line is the estimated minimum threshold for income considered as adequate to achieve the basic standard of living in a country. It is an official standard for determining the proportion of a population living in poverty (8).
Marginalized Group	European Institute for Gender Equality (EIGE) defines a marginalised group as: "Groups of people within a given culture, context and history at risk of being subjected to multiple discrimination due to the interplay of different personal characteristics such as sex, gender, age, ethnicity, religion or belief, health status, disability, sexual orientation, gender identity, education or income, or living in various geographic localities" (9).
Vulnerable Group	Vulnerable groups are a population who are affected by multiple processes of exclusion that can lead to or result from health problems (8)

Abstract

Introduction: People with disabilities (PWDs) in Nigeria face numerous challenges in accessing and utilising sexual and reproductive health and right services (SRHR). Policies and laws fail to address their SRHR needs. PWDs are discriminated against and excluded from the provision of sexual reproductive health services. The main aim of this study is to assess the factors that influence people with disabilities to access and utilise SRH services, and to identify effective SRH model of approach.

Method: Data search was done on PubMed and NCBI databases and through Google and Google scholar search engine. Literature review of articles, policy documents and project reports from 2005 to 2020 were used to synthesise findings. Modified Andersen and Newman model of Healthcare utilisation as a conceptual framework was used in exploring the factors influencing access to SRHR services.

Results: People with disability are limited in access and utilisation of SRHR services in Nigeria due to environmental, health system and individual factors. Disability non-inclusiveness in SRH policies; harmful socio-norms, beliefs and misconceptions about disability are environmental factors influencing the health system and limiting PWDs from accessing and utilising SRHR services. The negative attitude of provider towards PWDs, disability unfriendly infrastructure at health facilities, inadequate skills and information, and communication barriers constitute the health service factors. Predisposing factors (age, sex and ethnicity), enabling factors (income, education and support network) and need factors (knowledge and awareness and perceived need) are individual factors closely interlinked to affect access and utilisation of SRH services.

Conclusion and Recommendation: The challenges faced by people with disabilities are complex, and a multi-pronged approach is required to address these challenges. At a broader level, the government is obliged to ensure the design and enforcement of new and existing laws and policies that include PWDs. At a practical level, concerted efforts from government, donor agencies, SRH NGOs and advocates are required to address the barriers PWDs face in accessing SRHR services. Efforts should include raising awareness on SRHR and disability, making healthcare services more accessible and setting disability inclusion criteria for funding mechanisms.

Keywords: Access, Sexual Health, Reproductive Health, Service Utilization, People with Disabilities

Wordcount: 13,113

INTRODUCTION

I have been working with the Planned Parenthood Federation of Nigeria in the past six years supporting design, implementation and monitoring of SRH programme across several states in Nigeria. I have been involved extensively in supporting projects whose goals are to improve access to SRH services for poor, marginalised, socially excluded, and underserved groups (PMSEU). In November 2018, I became a member of a planning committee constituted at the regional level by International Planned Parenthood Federation, London. This committee was mandated to assess the capacity and progress of its member associations in delivering specific SRH programs for people with disabilities (PWDs). From that assessment, it was evident that despite PWDs being amongst one of the most marginalised and excluded groups within societies, their SRH needs had not been the focus of research nor programming by SRH focused organisations. PWDs were not engaged in decision-making or planning, and implementation of projects despite that these projects targeted PMSEU groups.

Taking the bold step to address the SRH needs of PWDs through policies or programme design and implementation requires in-depth insights beyond identifying their needs to analysing factors that will influence access to services. Numerous studies show that PWDs have equal needs as non-disabled persons. However, they often do not have equal access to SRH information and services; as a result, their SRH needs are mostly unmet with the risk of suffering worst health outcomes compared to non-disabled persons (10).

This thesis will explore various influencing factors for accessing SRH services for PWDs in Nigeria. Effective practices will also be identified as a reference for the replication of SRH policies and programmes. The recommendation section will contribute towards guiding SRH policymakers, advocates, implementers and SRH providers to prioritise, demand and strengthen disability friendly SRH services in Nigeria.

ORGANISATION OF THESIS

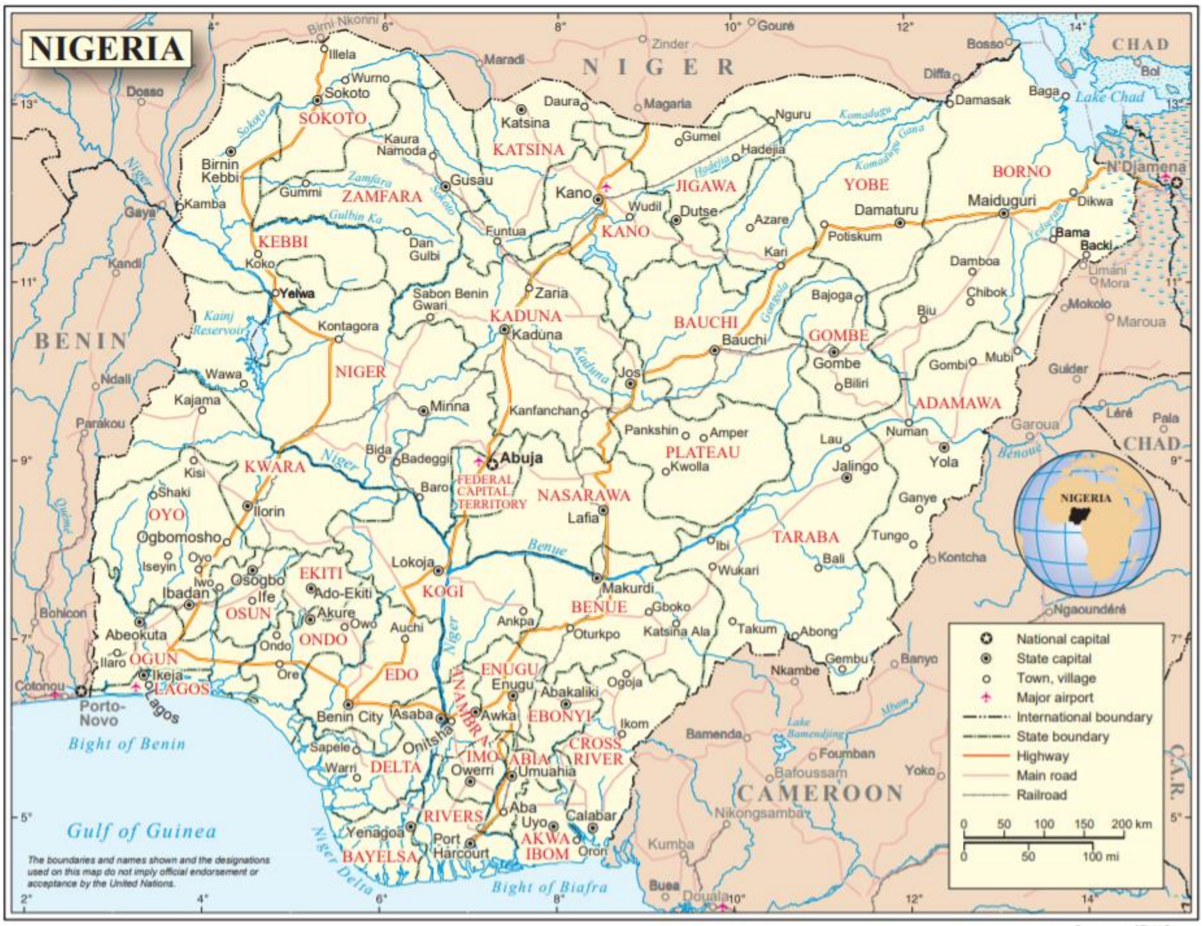
Chapter one of this thesis briefly describes the background of Nigeria. This section includes the socio-cultural and religious context and the dimensions of the health system. Chapter two gives an overview of SRH and disabilities, while chapter three begins with an overview of SRH issues as experienced by PWDs. It also focuses on the objective, methodology and conceptual framework. Chapter four zones on the major findings of factors influencing access to SRH services for PWDs by following three main dimensions of Andersen et al.'s Model of Health Service_ environmental factors, health system factors and individual factors. Chapter five introduces evidence of effective interventions to improve access to SRH services for PWDs. Chapter six focuses on discussions around the key findings and is followed by chapter seven, which highlights specific recommendations for improving access to SRH services for PWDs.

Chapter 1- BACKGROUND INFORMATION OF NIGERIA

1.1 Country Profile

Nigeria is situated in West Africa and bordered by Cameroon to the east, Benin to the west, Niger to the north and Gulf of Guinea to the South. It has a surface area of 923,770 square kilometres and a population density of 223.15 per square kilometre. There are 36 states in Nigeria and the Federal Capital Territory Abuja, as shown in figure 1. There are 774 local government areas (LGA) further divided into wards with 10-15 wards per LGA.

Figure 1: Map of Nigeria (13)



Nigeria's population is currently estimated at 203,139,589 million people, with a current population growth rate of 2.62% and about 50% of the population live in rural areas. The Nigeria populace is young, with 62% of the people below 25 years of age. The overall median age is 18.1 years for both males and females with an average life expectancy of 54 years. The average adult literacy rate is 59.6%; 69.2% of males and 49.7% of females (11).

1.2 Economy

According to the United Nations Development Programme (UNDP) Human Development Index, Nigeria ranks 157th out of 188 countries (12). The World Bank Organisation in 2018 estimates that about 50% of the population live below the international poverty line, subsisting on less than $1.90 per person per day (13). In the year 2019, Nigeria's gross domestic product was estimated at US $2,229.9 per capita. From 2006, the GDP growth rate had declined from as high as 8 % to as low as 1.5 % in 2016. It, however, improved to 2.55% in 2019 (14). Crude oil is the primary source of the economy as it accounts for

10% of the country's GDP, 70% of government revenues and more than 83% of foreign exchange earnings. Another key source of the economy is agriculture; it accounts for about 21.2% of the GDP and serves as the primary source of sustenance for over 80% of rural households (15).

1.3 Socio-Cultural and Religious Context

Nigeria is highly diverse culturally with about 371 ethnic groups and a population that is predominantly Muslim (48.8%) and Christian (49.8%) religion (16). Much of the Muslim population reside in the North while Christians are in the south with a resultant political and economic divide. Within these divides, states in Nigeria further split into six geopolitical context zones_ north-west, northeast, north-central, south-west, south-south and south-east region.

Nigerian majorly follows and practices a patriarchal system where women suffer discrimination and subordination. On the Global Gender Index, Nigeria ranked 133 out of 149 countries (2019), thus making it amongst the worst countries where gender disparities exist (12). There are several other harmful religious and socio-cultural norms and practices prevalent in the society which negatively impacts the health and the quality of life in general, especially for women and girls. Some of these practices include the preference of a male child over females. Socio-cultural norms limiting young people and unmarried individuals from using contraceptives and beliefs that some severe illnesses and misfortunes have a spiritual underpinning, thus resulting in stigmatisation and discriminations of persons affected (17). Also, cases of gender-based violence (GBV) are growing astronomically in Nigeria, with nearly 3 in 10 women experiencing sexual violation by age 15 (18).

1.4 Health System

The country's health sector is typically characterised by inadequate health infrastructure, insufficient and poor management of human resources for health, poor quality of healthcare services, and inequitable distribution of resources (19). Evidence from the National Health Accounts (NHA) suggests most states, on average, spend less than 5% of their total expenditure on health care. All tiers of government expenditure on health amount to less than 6.5 % of total government expenditure and less than 23.9 % of total expenditure on health in the country (19). The private sector accounts for the remaining 76.1% of healthcare expenditure, with 90% of it being direct out-of-pocket expenditure by households. Given that out-of-pocket is the most significant proportion of private healthcare spending, households, and individuals, especially the poor and vulnerable, incur catastrophic health spending, which further exposes them to financial risk and in the extremity can result in poverty (20).

An underfunded healthcare system contributes to the poor health indices recorded in the country. The poor health indices are illustrated by the high maternal mortality ratio of 512 per 100,000 live births, and a neonatal mortality ratio of 69 per 1,000 live births as of 2018 (21). Out of an estimated 40 million women of reproductive age, only 14% use modern contraceptives. About 9.5 million women have an unmet need for modern contraceptives. Of this population, 74% do not make use of any contraceptive method, while 26% use traditional methods, which typically have low levels of effectiveness. The lack of access to modern contraception results in 90% of all unintended pregnancies and more than half of unintended pregnancies according to Guttmacher Institute, end in induced abortion, while about 32% end in unplanned births. complications from induced abortion and unplanned births account for nearly 45% of maternal mortality in Nigeria (22).

Although it is also important to note that every individual deserves the right to sexual reproductive health (SRH) services, several factors exist that influence access and uptake in general (23).

Chapter 2- OVERVIEW OF SEXUAL REPRODUCTIVE HEALTH AND DISABILITY

2.1 Defining Sexual Reproductive Health

Sexual health was first formally defined in 1975 by the World Health Organization (WHO) (24) as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (pg. 4). Two decades after, this definition evolved, and the term sexual health was included as part of the definition of reproductive health during the 1994 International Conference on Population and Development (ICPD). The definition of reproductive health was therefore defined beyond the absence of any reproductive health-related disease to instead "the attainment of a complete state of "physical, mental and social wellbeing with one's sexuality" (25).

SRH is considered as part of the fundamental human right of every individual. This implies that every individual has the right to choose and make decisions relating to their sexual and reproductive health (SRH) without constraint, discrimination and violence (25). It is, therefore, essential to note the several components of SRH services desirable for use for SRH to be attained. According to ICPD (23), SRH services include the following:

i. Information, education, and counselling on sexual reproductive health rights.
ii. Family planning
iii. Antenatal, safe delivery, and postnatal care
iv. Prevention and management of Infertility.
v. Prevention and management of the consequences of abortion
vi. Prevention, care, and treatment of sexually transmitted infection (STI) and Human Immune Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) - related diseases.
vii. Prevention, surveillance, and management of gender-based violence
viii. Referrals for further diagnosis and management of SRH-related cases

Many countries over the years, including Nigeria, have made great strides in ensuring the provision of SRH services through policies and programmes. However, a considerable gap exists in implementation, mainly when it targets vulnerable and marginalised groups (26). People with disabilities (PWDs) are among the most vulnerable and marginalised groups as they are very often excluded and denied information and access to SRHR services. Their SRH rights are contested and debated as societies disregard their aspiration for a life of partnership, active sexuality, and parenthood (10).

2.2 Overview of Disability

The way disability is understood influences the way individuals think and behave towards disability or PWDs. The way PWDs are treated will impact on their ability to participate in society. Disability from a medical point of view is described as an illness or physical condition intrinsic to an individual which causes disadvantages to the individual (medical model of disability). Stucki (2003) suggests that such a view is what has led to stereotyping and defining PWDs by their conditions and limitations (27). WHO, however, in 2001, redefined disability by looking at disability beyond an impairment to instead looking at the negative attitudes, system barriers and exclusion by the society, which causes disadvantages to PWDs and contributes to "disabling" people (social model of disability) (28). In other words, the social model of disability holds a view that people have impairments, but 'disability' is the additional disadvantages inflicted by the society which treat these impairments as "abnormal" thus excluding them from full participation in the society.

The biopsychological model of disability synthesised both the medical and social point of view. The biopsychological model of disability instead views disabilities as a combination between an individuals' medical condition and impairment and other contextual factors (social and cultural environments as well as the physical and psychological factors such as age, gender and behaviour)(29).

The United Nations on Convention on the Rights of Persons with Disabilities (UNCRPD) further represents a view on disability from a human rights perspective (10). UNCRPD defines disability as ‘long-term physical, mental, intellectual, or sensory impairments’ which, in interaction with various barriers, lead to social and economic disadvantages, denial of human rights, and limited opportunities to fully and actively participate equally in the society as others (pg. 4) (10). Conclusively, although there are various and noteworthy differences between the models of disability, they are all necessary and contribute to understanding disability.

Chapter 3- PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES AND METHODOLOGY

3.1 Problem Statement and Justification

According to the World Bank, an average of 15% of the world's population, an estimated one billion people live with disabilities, with about 80% residing in developing countries (30). In Nigeria, the 2006 population census reported approximately 3.3 million PWDs—about 2.32% of the total population; however, the Centre for Citizens with Disabilities refuted these figures suggesting the census did not capture the full extent of disability in Nigeria (31). Also, in 2011, WHO in the World Report on Disability stated that about 25 million Nigerians have at least a form of disability, while about 3.6 million of them experience significant difficulties in functioning (32).

In 2013, the Nigerian National Assembly estimated over 20 million people to be living with disability in the country (15). While in 2018, the Nigeria National Population Commission (NPC) estimates put the total number of PWDs at about 19 million people. Within the same year, the president of the Network for the Advancement of Persons with Disabilities, however, stated that approximately 27.3 million Nigerians live with various forms of disabilities (15). These varying estimates raise the question of the credibility and robustness of the statistics of PWDs in Nigeria. However, despite data inconsistencies as highlighted, what remains quite clear is that between 2006 and 2018, the estimated number of people found to be living with disability was shown to have risen from 3.3 million to about 27.3 million. The Population Reference Bureau also reports that disability prevalence will continually increase as population growth rate, the burden of non-communicable diseases, and the occurrence of conflicts and poor economic performances rises (28).

PWDs, in general, experience social and economic marginalisation (32). According to the Federal Ministry of Health (FMoH), the majority of the PWDs are poor and reside mainly in rural parts of the country where there is an absence of clean water source, essential sanitation services and rehabilitation service. They also must deal with the challenges of restricted employment and educational opportunities. PWDs are at the risk of experiencing chronic illness as the lack of sustainable income flow coupled with the lack of better healthcare and infrastructures such as roads, and appropriate transport system limits their ability to access health services(34).

The lack of appropriate transport system makes it challenging to reach facilities and communities where SRH services are available. When they eventually reach the facilities, they very often experience other challenges ranging from difficulties with physical access—entering and navigating the health facilities to the lack of health care services tailored to the needs of PWDs (35). In a situational analysis brief by the Disability Rights Advocacy Center (DRAC) of Nigeria, WWDs mentioned the lack appropriate signages for people with impaired sights; ramps or open entry doors with the required clearance width and space, accessible restrooms and hallways and non-adaptation of information, communication and education materials relevant for their SRH needs as significant challenges (34). This brief also makes mention of the attitude of the service provider and the inadequacy of service provider skills as some of the difficulties experienced with accessing healthcare services (34).

Several other factors also affect access to healthcare services for PWDs. These factors range from the lack of favorable SRH policies to discriminations resulting from socio-cultural factors against PWDs, especially women and girls (32). The SRH needs of PWDs are inadequately integrated into several national policies relevant to reproductive health policies. Programmes and Interventions lack disability inclusion to address the health needs of PWDs. Besides, the presence of religious and socio-cultural biases and discriminatory attitude serve as significant contributors to the marginalisation and increased vulnerability of PWDs (32)

The marginalisation of PWDs has severe cost implications on not just families but for the economy at large (36). On average, a higher percentage of PWDs live in poverty and are more likely to suffer catastrophic health spending (30). An analysis of the World Health Survey data for 15 developing countries confirms that households with disabled members incur relatively higher healthcare costs than households without a disabled member (37). The extra cost of healthcare is a primary source of risk not only for the individuals but also for their families as increased healthcare spending may have an impoverishing effect on households and may prevent or delay individuals from seeking healthcare services (32). Failure to seek healthcare services or a delay in accessing healthcare services may further result in worsening health conditions, including the development of additional disabling conditions (38).

On the other hand, poor health conditions can restrict meaningful participation in education and employment, resultantly affect income flow over time, and the possibility of contributing meaningfully to the growth of the economy (43). Several studies (39,40) confirm this by showing that employment and income outcomes worsen with the severity of a disability. A 2005 study by the Leprosy Mission of Nigeria found that 61 % out of 1093 respondents who had a form of disability or the other were unemployed because of their disability (41). According to a study by the American Institute for Research, working-age persons with disabilities would have as much significant spending power, which can contribute to the growth of the economy as would non-disabled persons if the labour market were fully inclusive of PWDs (42).

Research by a disability activist group puts women with disabilities (WWDs) in Nigeria at 20% of the total population (45 million) of women of reproductive age (43). The United States Agency for International Development (USAID) opines that women and girls often face “double discrimination” on account of their gender and disability status. They also experience far worse discrimination when they belong to marginalised ethnic groups or communities such as lesbians, transgender, bisexual, and female sex workers (44). According to a situational analysis report on the SRH of WWDs in Nigeria, women report being neglected and discriminated against by healthcare providers, caregivers, and other community members (15). The 2013 study assessing the experience of girls with hearing impairment in accessing SRH services in Ibadan, reported they were excluded from service provision. They were not provided with professional interpreters during visits to SRH facilities, and they had to rely on family and friends to translate information to them. The absence of privacy and confidentiality limited their willingness to access services and their ability to make informed decisions concerning their SRH rights (45).

In the situational analysis brief by the DRAC, women also reported being sexually abused and exploited with limited opportunity to receive medical, legal, or psychosocial support. Harmful practices, beliefs, and gender norms increased their risks of not only being abused physically and sexually but of being entirely neglected without so much as taking into account their SRHR needs (34). Healthcare providers have a misperception about WWDs being sexually inactive and would not screen them for sexually transmitted infections or provide them access to contraceptives (46). Local beliefs attributing disability to a mother's sin promiscuity, an ancestral curse, or demonic possession negatively influence the healthcare-seeking behaviour of WWDs and quality of service provision to WWDs. In other instances, pervasive beliefs suggesting that having sexual intercourse with a disabled woman will fetch a man more wealth. These beliefs contribute to the discrimination of PWDs, including exclusion at various levels (family, society and health facilities (47).

Discrimination in the provision of SRH services to WWDs has significant public health implications (30). Using HIV as an illustration, treatment for HIV in LMICs, cost 8,900USD per person over a life-course in contrast to an estimated 11USD to prevent one case of HIV (36). Evidence shows that persistent discrimination increases their vulnerability to SRH diseases, including HIV thus, agreeing with the findings that show that PWDs are at increased risk of contracting HIV and are more likely to contribute to the burden of new

HIV infections. An increased HIV incidence amplifies government spending on HIV care and treatment programmes (48). This impacts on the health sector budget and may potentially lead to spending cuts for other health programmes. Furthermore, discrimination in the provision of SRH undermines the potential for any improvements in population health (49)(50).

The non-inclusion of PWDs in SRH services and programming has severe implications on the efforts of Nigeria in achieving Universal Health Coverage as it leads to a continued propagation of health inequalities (51). Thoraya Obaid (Former Executive Director, UNFPA) in 2007 states that the goal of achieving universal access to SRH cannot be achieved unless PWDs are mainstreamed and included in programmes to improve their health (23). Nigeria National Health Act (NHA) was signed into law in 2014 on the premise of equitable and inclusive health for all, and with it came commitments by the government to provide comprehensive and integrated SRH services for all Nigerians. The country, however, remains far from fulfilling this commitment, especially as it fails to recognise WWDs in its implementation (34).

A report by Ruth Douglas, a disability activist, points to the fact that there are evidence gaps in the health needs of PWDs, including effective policies and programmes aimed at improving their health (52). She further suggested that while the lack of evidence often impedes implementers from being able to design programmes to address their needs, it also fuels inaction by the government. Furthermore, research evidence is critical to understanding the SRH needs of PWDs. Research insights into the challenges PWDs encounter with the fulfilment of their SRH needs is imperative to inform the formulation of policies and design of effective interventions that support meeting those needs. It is also critical to strengthening the health systems that will be responsive to the SRH needs of PWDs.

3.2 Objectives

Overall Objectives

The overall objective of this study is to analyse factors that influence access and utilisation of SRH for people with disabilities and to provide recommendation for increasing the accessibility of SRH services based on evidence-based SRH programmes for people with disabilities.

Specific Objectives

1. To analyse factors influencing access and utilisation of SRH services for people with disabilities.
2. To identify interventions or programmes that have been effective in improving access to SRH services for people with disabilities.
3. To make recommendations to the Federal Ministry of Health, policymakers, civil society organisations and disability advocates such as the Joint National Association of Persons with Disability to adopt SRHR policies and strengthen advocacy and interventions to address the SRH needs of people with disabilities in Nigeria.

3.3 Research Methodology

The study design employed was a literature review. Data were obtained from peer-reviewed and grey literature, policy documents and project reports. Given resource and time constraints, a literature review was more suited to generate evidence in line with research objectives. Synder (53) opines that a literature review is capable of integrating perspectives and findings from several empirical findings. In other words, it addresses research questions with a combined power of several studies. The review was, therefore, useful in synthesising research findings to show evidence on factors influencing access to SRH services for PWDs.

Data Sources and Search Strategy

This study made use of PubMed and NCBI databases to search for peer-reviewed literature. Search terms included several keywords and MESH terms such as "Access", "disability", "women with disabilities", "sexual health," "reproductive health" "maternal health", "HIV" and "interventions" applied in combination with names of the countries and applied in search engines using Boolean operators "AND and "OR". The search limits were restricted to literature published in English in the past fifteen years (from 2005-2020) and conducted in Nigeria and other LMIC countries. Titles and abstracts were reviewed and used to select full-text publications addressing the sexual reproductive health of people living with disabilities. To further broaden the pool of literature, articles focus on only women with disabilities or specific SRH components such as HIV and Family Planning were included. Upon full review, those not meeting the above inclusion criteria was excluded. Relevant articles where full access was not obtained were extracted going through VU-e-library. Furthermore, a search of grey literature was conducted primarily through Google and Google Scholar search engines and on websites such as World Bank, WHO, UNFPA and FMoH. Additional literature was identified through snowballing of the reference section of some literature selected from databases and websites for other relevant articles to ensure optimal inclusion of publications. Keywords used for the review are listed on Annex 1

Finally, to examine the disability-inclusiveness of SRH related laws and policies as an influencing factor in Nigeria, a combination of keywords "sexual health," "reproductive health," "policy," "strategy," and "persons with disability" and "legal framework" were applied on Google search engine. National policy and strategy documents were also searched on the websites of the Nigeria Federal Ministry of Health. Policy documents with the most recent dates and published by the Federal Republic of Nigeria was selected

3.4 Methodology Limitation

The literature review approach constrained the provision of new insights into challenges experienced by PWDs with accessing services that could otherwise have been gotten from key informant interviews. It also prevented the ability for a more complex analysis of the barriers that exist in the societies which affect access to SRH services. Such in-depth insight would require an exploratory study of PWDs experiences and stakeholder and healthcare providers view.

3.5 Conceptual Framework

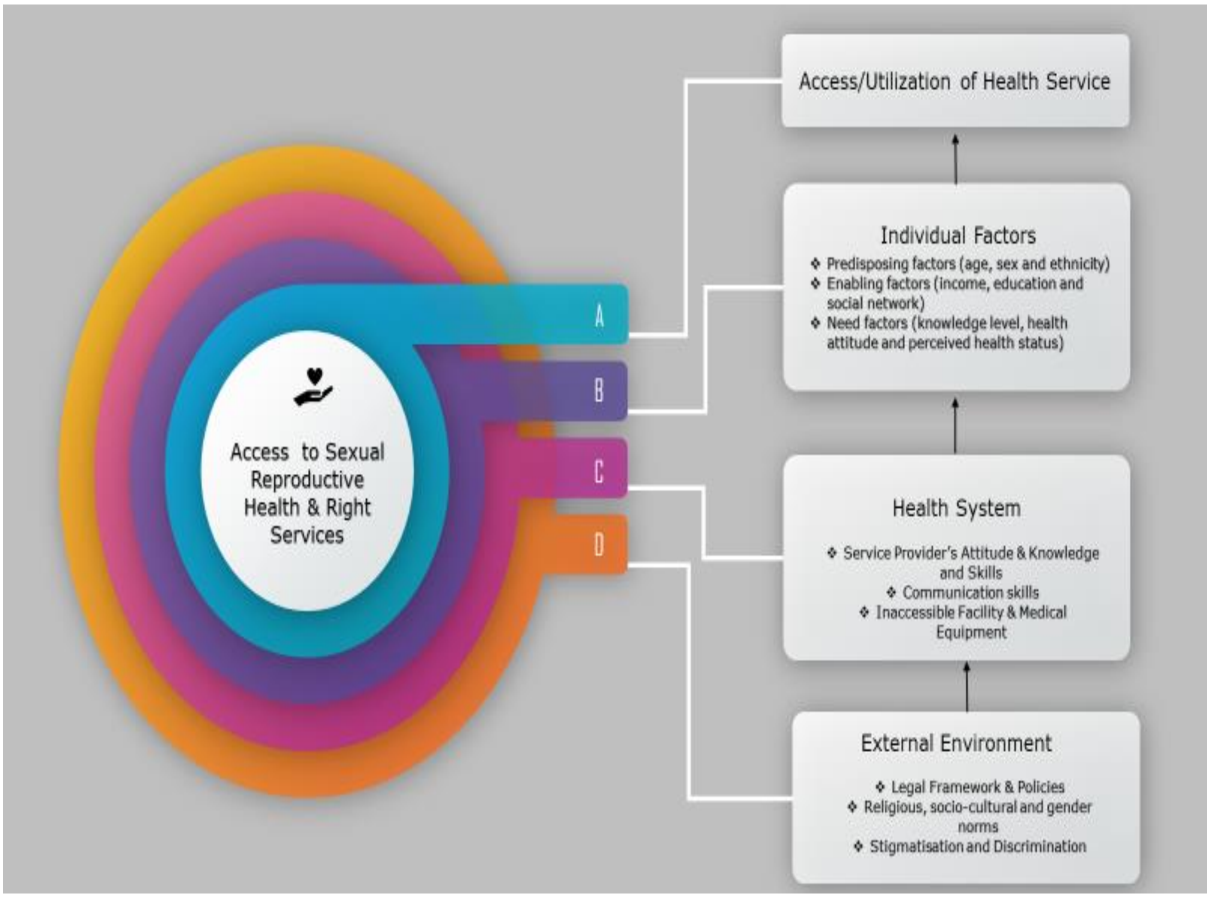
The term "Access" according to Donabedian, 1972, is described as the opportunity or ease with which individuals can reach and utilise appropriate services in proportion to their needs (54). This definition also encompasses the factors or characteristics that influence the initial contact and utilisation of services. Anderson and Newman Model of Health Service Utilization (Phase 3) (55) (Annex 2) was modified for use in this study to understand the factors influencing access to SRH services for PWDs. Penchansky and Thomas Model was considered. However, it fails to capture the dimension of knowledge and awareness as an influencing factor on access to healthcare services within any of it domain (54). Levesque et al.'s accessibility framework (56) was also reviewed. Although it is a relatively useful tool for identifying the range of barriers that impact access as well as ways in which to address it, the linearity of this framework was found to be unsuitable for accurately portraying the interrelationships between the various features of access. For example, a much closer relationship was found between users' income and ability to pay and the ability to reach the facility than the linear framework suggested by Levesque et al. (2013). It also gives less attention to the external environment (policies) which, according to Aday and Andersen (1974), is a critical dimension for understanding the use of health service (57).

Anderson and Newman Model of Health Service Utilization (Phase 3) was selected over the models above because of its comprehensiveness. While it incorporates both the individual and contextual determinants of health service use, the contextual factors range from socio-cultural norms, policies to supply-induced factors. This model also allows for analysis beyond individual and contextual factors as it includes the outcomes domain as the endpoint of interest. However, for this study, measuring the outcomes as a measure of access will not be considered. To establish such a connection would require measuring the health outcomes indicators in a sample population over time. This cannot be achieved for this study, given the time and financial constraints. The model (figure 2) was modified to represent a non-linear interrelationship of the influencing factors and to organise the various entry points for addressing the barriers to access under each domain.

Anderson and Newman Model of Health Service Utilization (Phase 3)

Within this study, the framework conceptually organises the factors that influence access to healthcare services as determined by the interaction of three main domains (58). The first domain consists of the characteristics of users as an inclination to use health services— predisposing factors, enabling factors, and need factors. Predisposing factors include age, sex, and ethnicity. Enabling factors are the resources that facilitate or impede access to services such as users' educational level, income, support network, and appropriate SRH interventions. According to the model, the need factors at an individual level refer to the users’ knowledge and understanding of health services, the users’ perception of need for a health service and subsequent, health attitude. These three factors are considered the significant determinants of health practices and health-service use (59). The model also acknowledges the potential impact of the health system (human and material resources, knowledge, and skills) and the external environment (policy and socio-economic context) on the characteristics of users and their influence on access.

Figure 2: Anderson and Newman Model of Health Service Utilization (Phase 3) (60)



Summarizing Review Findings

In analysing the review findings, the Anderson and Newman Model of Health Service Utilization was conceptualised as various factors that present logical linkages at different level (figure 2). Each of the reviewed literature was compared with each factor to investigates whether a particular factor specified in the conceptual model (e.g. Health system factors such as service providers attitude, inaccessible facility and medical equipment) was studied in the literature under review. If a variable factor was included in the literature, results were summarized from all literature involving that variable factor to determine the role it plays in influencing access to SRH services for PWDs. Also, linkages between various factors from one level to another are established.

Chapter 4- FACTORS INFLUENCING ACCESS TO SEXUAL REPRODUCTIVE HEALTH SERVICES

The chapter identifies and describes the factors influencing access to sexual reproductive health services among people with disabilities (PWDs) in Nigeria in line with the conceptual framework described in the previous chapter above.

4.1 External Environment

This section focuses on the disability-inclusiveness of SRH related policies in Nigeria

Law & Policies

In addition to Nigeria being a party to the International Covenant on Civil and Political Rights (ICCPR), which requires that states respect, protect, and fulfil the rights of women with disabilities. Nigeria has also ratified the following international treaties that make it binding on the government to prevent discrimination and protect the sexual reproductive health and rights (SRH) of persons with disabilities (60).

1. United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[1].
2. Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[2].
3. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)[3]

According to the constitution of the country(61) in section 12(1),(2) & (3)[4], it is evident that the domestic application and the legal enforceability of these treaties are restrictive. Thus, owing to the dualist system of the country. The constitution, though, prohibits discrimination based on sex under section 42; subsection (2)[5], it does not, however, contain provisions that directly address discrimination based on disability. Furthermore, at the time of drafting this report, a national law that gives a comprehensive framework for the prevention of discrimination against persons with disabilities in Nigeria was not in existence except for several states that had adopted the provisions of CEDAW into law by enacting the Gender quality and disability rights law.

The National Gender Policy(62) acknowledges the SRH challenges as experienced by women, which include GBV and discrimination and lack of access to sexual reproductive health information and services. However, it does not address these issues as it relates to WWDs, despite that they experience far worse of these situations than non-disabled persons(32). This policy document only mentions WWDs in relation to ensuring access to education, politics, and cultural life.

A Gender and Equality Bill (63) that encapsulated significant documents concerning gender equality, such as CEDAW and National Gender Policy 2006, was proposed in 2011. It contained provisions to guarantee the prohibition of discrimination and all forms of violence against women, especially WWDs. It also contained provisions that protect

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[1] Convention on the Rights of Persons with Disabilities adopted Dec. 13, 2006, arts. 2 & 5, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (entered into force May 3, 2008).

[2] Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR (34th Sess.), Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (entered into force Sept 3, 1981) (ratified by Nigeria April 23,1984).

[3] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR (39th Sess.), Supp. No. 51, at 197, U.N. Doc. A/39/51, 1465 U.N.T.S. 85 (entered into force June 26, 1987). (ratified by Nigeria June 28, 2001).

[4] 12(1) No treaty between the federation and any other country shall have the force of law except to the extent to which the National Assembly has enacted any such treaty into law.

12(2) The National Assembly may make laws for the federation or any part thereof with respect to matters not included in the exclusive legislative list for purposes of implementing a treaty.

12(3) A bill for an Act of the National Assembly passed pursuant to the provisions of subsection 2 of this section shall not be presented to the president for Assent, and shall not be enacted unless a majority of all the Houses of Assembly in the Federation ratifies it.'

[5] 42(2) No citizen of Nigeria shall be subjected to any disability or deprivation merely by reason of the circumstances of his birth.

reproductive health and prohibits discrimination in the provision of health care, although without referring WWDs. At the time of submission of this report, the adoption of this Bill was still pending.

The Anti-Torture Act of 2017 (64) was adopted towards legal protection against specific forms of torture but failed to include provisions for protection against cruel, inhuman, degrading treatment or punishment, which is required according to Article 7 of ICCPR(65). It also does not prohibit abuses or mistreatment in health care settings, such as verbal and emotional abuse by healthcare providers, forced sterilisation, forced contraception, and forced abortion performed on WWDs without their informed consent. This, according to the Human Rights Committee, is classified as torture (66).

The HIV/AIDS (Anti-Discrimination) Act adopted in 2014(67) contains provisions that prohibit discrimination based on HIV status, whether through service provision or by individuals, including outlawing socio-cultural practices that may increase the risk of HIV transmission. However, PWDs are not referenced in the Act and their situations not addressed. For instance, young women and girls with disabilities experience sexual violence and discrimination, such as the lack of access to comprehensive sexuality education and contraceptive services, which increases their exposure to HIV(68). This is not addressed in the Act and, as such, a lesser possibility of being implemented or enforced.

Nigeria has several national policies relevant to SRH, yet some of them fail to address the SRH needs of PWDs adequately. For example, in the National Reproductive Health Policy and Strategy (2014-2018)(69); likewise, the National Strategic Plan on HIV/AIDS (2017-2021) persons with disabilities were only mentioned once as an inclusion to the broader target group. These documents do not specify strategies and interventions to address their SRH needs despite that adaptation of existing SRH services are required to accommodate PWDs. The National Strategic Health Development(70) Plan emphasises the concept of "leave no one behind" and acknowledges the weakness of the health sector in service provision to persons with disabilities. However, it does not highlight specific strategic interventions to address the reproductive and maternal health needs of PWDs besides the mention of the need to reduce stigma and discrimination of persons with mental disability.

It was not until 2018 that the Nigeria National Policy on Sexual Reproductive Health and Rights of Persons with Disabilities(71) was developed with the intent to bring the SRH of women and girls with disabilities specifically, into the country's health and development agenda.

Religious and Socio-Cultural Norms

Although very few studies exist on the link between socio-cultural factors and the SRH of PWDs in Nigeria, available studies do well to show the impact of misconceptions on disability, socio-cultural norms, and religious beliefs on access to health services in general. The findings of such studies have been extended to this review and applied to "access to SRH service component."

Inclusive Friends Association (IFA) and the Nigerian Stability and Reconciliation Programme (NSRP) conducted a qualitative study to document the experience of women and girls with disabilities in Plateau state (72). In this study, WWDs reported that community members perceived them as cursed or witches responsible for misfortunes. As a result, they were often refused assistance and support by community members. In rural areas, respondents indicated that women had an increased likelihood of being raped because of the superstitious belief that having sex with WWDs, particularly those with psychosocial and intellectual disabilities will bring status, wealth, and power. Though, while the above study was conducted within the northern part of Nigeria_ where they are predominantly Muslims_ the socio-cultural norms and beliefs are distinctively different across the six regions of Nigeria, which may also affect generalisation of the resultant effect of such belief. In another scoping review on the attitude of Nigerians towards people with mental disabilities, preternatural or supernatural forces as being responsible for mental disability was expressed in 36% (9 out of 25) of articles scoped (73). Adolescents mentioned they preferred not to present at health facilities to seek help or even to admit being mentally impaired because of the beliefs attributing mental impairment to "evil forces" (74).

In an exploratory study on sexual harassment, social media, and rape discourse in Nigeria (75), findings showed that the social norm of disbelief and victim-blaming for women who experience GBV exist widely and is worse for WWDs. For example, a woman with visual impairment may be unable to identify the perpetrator or a woman with mental disability may find it difficult to report or narrate her ordeal. Similarly, in a study (7) to understand the social, cultural, and institutional factors that contribute to the sexual abuse of PWDs in East Africa, reports of the ordeal of survivors were disregarded because of the belief that violating a WWDs was rather beneficial to her. The quote by a WWDs_ "***they think it is good luck for the disabled person to have this [sexual abuse] because nobody is ready to do the thing in a good way"_*** proves how perpetrators justify the sexual violation of disabled women.

Stigmatisation and Discrimination

The study by IFA and NSRP (72) women and girls with disabilities reported being violated and discriminated against without having access to support services within the justice and healthcare system because of stereotypical beliefs that saw them as "less human", "illiterate" and "repulsive". For example, 63% of WWDs reported they were violated by caregivers and 11.4% by security agents. The researchers also uncovered examples of WWDs attending universities who reported they were also sexually exploited and violated by lecturers offering to help them access learning materials. More worrisomely, these women reported that they were reluctant to report the cases because of fear of being threatened or experiencing further mistreatment or violence in the hands of the perpetrators. Survivors also reported that SRH services were unavailable to them. The researchers, however, call for caution regarding these findings due to the small sample size. While it might not have been statistically significant, it points to an area requiring further investigation. Besides the extent to which SRH services are available to survivors also depends on the place of residence and available resources within those locations.

The experiences of WWDs, as documented by IFA and NSRP (72), suggested that WWDs were stereotyped and discriminated against compared to the men who, despite their disabilities, are more accepted. WWDs reported communities perceived them as unfit for marriages or safe motherhood experience: ***"There's this general notion or mentality (wrong mentality) that women living with disabilities can't live a 'normal' life or can't get pregnant or raise a family of their own. So most times, it is difficult for women living with disabilities to get into a relationship and when they eventually do, the in-laws most times kick against such relationship, and such experience can traumatise or leads to emotional and psychological depression."*** With such a notion, they felt restricted to express their need for reproductive health services freely. Perhaps PWDs are more likely to experience such type of discrimination and stereotypical attitude in a society where the level of educational attainment is low. A study by Akasreku et al. (76) to explore community attitude to pregnant WWDs, showed that there was a statistically significant association ($p<0.001$) between education and negative attitudes and perception towards pregnant WWDs. Community members of lower educational status were the ones who formed negative perceptions and displayed negative attitudes towards pregnant WWDs.

4.2 Health System Factors

Health system factors that influence access to SRH services consist of service providers attitude and capacity, communication skills and facility accessibility (physical infrastructure, adapted medical equipment and proximity to the health facility). Although no study in Nigeria was found to show how facility accessibility influences access to SRH services for PWDs, result findings from available literature from Zimbabwe shows that majority of WWDs cited long distance to the facility and inaccessible buildings and facilities as one of the major impediments to accessing SRH services (77). WWDs interviewed reported that the health facilities were not built, taking into consideration people with disabilities. Facilities lacked ramps and appropriate toilet facilities. Navigating the building was challenging, and in some cases, they had to pay to use wheelchairs. In a Ugandan case study (78), WWDs who wanted to access maternal health services reported that the examination, delivery and maternity beds are too high and therefore not suitable for their use. They also reported that the waiting room seats and sanitary facilities were not appropriate for use by people with mobility disabilities. This was further illustrated by a quote ***"you would find the latrines dirty, but I had nothing to do [implying she had no choice but to use the latrine in that dirty state] I would crawl in that messed-up place like that. The facility does not have separate latrines for disabled people (WWD)."***

According to a study by Burke et al. (2017) (79) conducted in Senegal amongst YPWDs, many of the informants in an FGD who accessed SRH services did so at facilities they said they felt were in proximity to their homes. Many also reported confidentiality, anonymity and proximity as reasons for choosing where to access SRH services. Pharmacies were cited more often as the primary source of SRH services or products due to the proximity. One of the weakness, however, observed with this study was that it lacked depth in the way some of the themes were explored as if failed to explain how confidentiality and anonymity influenced the decision of YPWDs to access SRH services.

The study by IFA and NSRP (72), showed that WWDs in Nigeria encountered attitudinal barriers around the acceptability of seeking SRH services. A pregnant WWD reported that providers expressed shock or disdain when they presented at health facilities to request contraceptives or prenatal services. A Ugandan case study (78) on the maternal and newborn needs of women with mobility disabilities, one pregnant WWD reported she was given wrong drug prescriptions because of the providers' inability to understand her maternal health problems. Similarly, in a qualitative study conducted in Philippine on knowledge, attitude, and practice of service providers in relation to WWDs accessing SRH services, many service providers in the FGDs said they felt they lacked the capacity to provide appropriate SRH services to WWDs (77). Some government representatives in the FGDs also reported that service providers had limited training on how to address the SRH needs of WWDs and, as a result, held a negative attitude towards them.

Contrary to the findings, a study on the experiences of girls with hearing impairment in accessing reproductive services in Ibadan (45), only a few (9 out of 151) reported the negative attitudes of providers. Instead, they felt healthcare providers lacked understanding of disability and the basic communication skills of sign language and interpretation, which they often found discouraging. Of the 151 respondents surveyed, 41.1% reported they were not able to make themselves understood by the health provider, 17.1% did not understand information by the provider, and 41.8% reported they missed their turn in being attended to because they did not hear their names called out.

4.3 Individual Factors

Predisposing Factors

With a minimal number of studies demonstrating how individual characteristics (age, sex, and ethnicity) influence access to SRH services for PWDs, it was necessary to analyse studies carried out amongst the general population and other African countries with similar context. In terms of the relationship between age and utilisation of FP services, a Ugandan study (80) found that older (> 21 years) WWDs had 1.09 times increased odds of utilising FP services compared to younger women (<20 years)(p=0.044). Nigeria's National Demographic Health Survey 2013 also reported low levels of contraceptive use mainly amongst adolescents (2% of 15–19-year-olds) compared to adults (16% of 20–49-year-olds) (18). Though these results are not adjusted by marital status, those married that fall within the younger age groups may have a much-needed desire to have more children hence the less use of contraceptives compared to those in the older age bracket. In another study by Kassa et al. (2016) (81) on the SRH knowledge and attitude of young people with disabilities (YPWD), results showed that level of SRH awareness increased with every additional year of age (aOR=1.2; 95% CI= 1.1-1.4). Now while healthcare-seeking patterns may vary between youth and adults because of their level of awareness, several other factors also explain why adolescents do not demand SRH services as much as adults. These factors include the age-related lack of autonomy in decision making, financial constraints and socio-cultural norms that often prevent adolescent girls, particularly in northern Nigeria, from seeking SRH services (82).

The results of a study on the HIV prevalence and sexual behaviours of 620 PWDs in Nigeria (83) showed that overall males (31%, n=310) had a higher comprehensive knowledge of HIV compared to females (19%, n=310). Additionally, HIV comprehensive knowledge was significantly higher among the southern region (64%) compared to the northern region (10%) ($p<0.001$). On the assessment of HIV risk perception, the northerners had a low HIV risk perception (7%) compared to the southern (2%). In this study, the difference in perception was explained by the socio-cultural difference between northern and southern Nigeria and the level of HIV knowledge. It also suggested that the education gaps between the southern and northern parts of Nigeria with the Northern part falling behind, explains why there is also a significant difference in HIV knowledge. The analysis here, however, does not disaggregate by disability type. PWDs are not a homogenous group, and therefore level of education, knowledge and perception of HIV may vary across disability type such as in the case of a person with intellectual disability and a person with mobility challenges.

Enabling Factors

Studies reviewed found consistent predictors of utilisation of SRH services at the individual level to include enabling factors such as education, income and support network. PWDs compared to non-disabled persons are less likely to be educated ($p < 0.001$) and less likely to be employed ($p < 0.001$) (84). In a study on access and utilisation of reproductive health services in rural Uganda (80), results showed that WWDs with secondary education and above were six times ($p=.049$) more likely to use FP services than those educated below a secondary level of education. Similarly, evidence from a cross-sectional survey conducted in Nigeria among PWDs showed an association between educational attainment and uptake of HIV counselling and testing (HCT) ($p<0.001$). While respondents with tertiary education had the highest proportion (72%) of those who had ever received HCT and received results, the lowest proportion (15%) were among those who had only Quranic education (83).

While a study by Kassa et al. (2016) shows a low level of education is significantly associated (aOR = 6.5; 95 % CI = 3.1–13.6) with low awareness of SRH (85), it also restricts the opportunity of employment and income generation amongst PWDs thus exacerbating the financial barriers of accessing healthcare services (79). In a qualitative study on the enablers and barriers to accessing SRH services among women with visual impairments in two regions in Ghana (85), the majority mentioned they experienced financial difficulties with paying for the cost of care and transportation due to the lack of funds. One of the participants expressly stated:

"I have to pay the transport cost of the person to accompany me to the health facility and also pay for my own to the health facility … when it happens like that I encounter financial difficulties … in about two years where I was in short of blood and presented at Asuoyin [health facility], I was in short of finance there, I paid the transport cost for the caregiver and also bought food for him to eat."

While this study offers unique evidence on the challenge of cost as a barrier to accessing services, it may, however, not be representative of the entire population of PWDs. The studies mentioned were conducted in rural settings, where circumstances like geographical terrain, distances, transport, and availability of healthcare services are problematic. Therefore, how PWDs in urban settings perceived cost and transportation challenges might differ from those in rural settings.

Furthermore, the above findings contradict findings from a study conducted by Arulogun et al. (2013) (86) which showed that out of 167 girls with hearing impairments who enumerated their experience with accessing RH services in Nigeria, the majority did not consider cost as a challenge. Only 10.8% said they could not afford the cost of healthcare. Important to note in this study, of all the girls who visited the health facilities, a parent accompanied 72.2% (114) of them. While, 18.9% were either accompanied by a supporting organisation, spouse, partner or relative, which further explains the possibility of the costs being borne by the accompanying persons. This finding is further substantiated by the findings of Badu et al. 2018; many of the women with visual impairment interviewed reported that cost was not a challenge, as illustrated by this quote:

"***My sibling who is my mother's last born brought me small money so I added some to cater for cost associated with the care… and she said she could not get time because she was travelling and nobody was around to support me so I beg the lady to accompany me… even with the family members, apart from my siblings, anyone who accompanies me collects money for the services."***

Besides the reliance on support networks to cover transportation and service cost, a study by Lee et al. (2015) further highlights the role of a support network as an influencing factor in accessing SRH services. In the FGDs conducted, service providers reported that the majority of WWDs relied on family members to either assist with mobility or as an intermediary between them and the service provider for communication purposes. Service providers also described family members as often acting as gatekeepers to SRH information. Similarly, in a study by Laura Dean et al. (2016) (87), the majority of WWDs reported family support as a necessity for accessing SRH services.

Need Factors

Evidence from a review of the literature suggests that the use of SRH services is influenced by need factors such as knowledge and awareness level and perceived need for SRH services (95,97). In a qualitative study (79) to explore the barriers and enablers for YPWD to accessing SRH services in Senegal, results showed that there was a significantly lower knowledge of available contraception methods amongst YPWD in the focus group discussions (FGd). Majority routinely mentioned only condom and occasionally pill. While some acknowledge the health benefits of using a contraceptive method, a majority had a misconception that contraceptive use would result in sterility. 65% (15 out 23) of informants interviewed who had sex, of which two were females and married, reported ever used a contraceptive and 35% reported never used a form a contraceptive method. The study also showed that across all disabilities and genders, the majority of YPWD reported they had never accessed SRH information and services majorly because they were unaware of SRH services or where to obtain it. One of the strengths of this study, as observed, was that the study was inclusive of a diverse group of YPWD's experience, thus implying that many YPWD irrespective of disability type have low knowledge of SRH services.

In contrast, findings from a study conducted in Gujarat state, India showed that the majority of the WWD reported being aware of SRH services. However, none of them perceived SRH preventive services necessary (87). It also agrees with findings by Doyle et al. (2010) that showed that the improved knowledge had no impact on change in perception of susceptibility to HIV infection (88).

Another study (89) conducted in Ibadan to explore the RH knowledge and sexual behaviours of 103 young persons with disabilities found that of those sexually active (35%), only 6% reported consistent use of a condom. The rest had either never used or were inconsistent. Overall, it was found that exposure to HIV education programmes was low, with 70%, indicating they did not know where to obtain reproductive health services if they required it. On the other hand, when the effect of peer education programme was compared among students with hearing disabilities, those who participated in the programme had their knowledge on HIV improved (from 48.9% at baseline to 56.3% post-intervention) and awareness (from 55.6% at baseline to 89.0% post-intervention). These results are consistent with the findings of Sannon et al. (2018) (90) which proves that exposure to SRH information influences knowledge on SRH, which in turn engenders a positive disposition towards seeking SRH information and services.

Chapter 5- EXAMPLES OF INTERVENTIONS OR PROGRAMMES TO IMPROVE ACCESS TO SEXUAL REPRODUCTIVE HEALTH SERVICES FOR PEOPLE WITH DISABILITIES

This chapter describes evidence-based interventions by non-governmental organisations in Kenya, Uganda, Burundi, Nepal, Ethiopia, and Zimbabwe. These countries were selected out of several others because the different NGOs are well recognised for their successful efforts in either making SRHR programmes disability-inclusive or for having their primary focus on disability inclusion (91). They are also good examples _in terms of availability of substantial evidence on project success_ for addressing the SRHR of persons with disabilities from a legal, policy and practical perspective. Besides, just as found in studies conducted in Nigeria, PWDs in these countries encounter similar barriers to accessing SRH services, from the weak implementation or enforcement of policies and laws and negative attitudes in the community to inaccessibility of services, information and communication to accessing SRH services.

5.1 Creating an Enabling Environment-Outcome 1

An enabling environment in the broad sense ranges from the role of families and communities to the role of the government and donor agencies in ensuring access to SRH services.

'Listening to the voice of the voiceless' implemented by the Federation for Deaf Women Empowerment Network – Kenya (FEDWEN-K) and Amplify for Change

As part of the initiative to increase access to SRH services, FEDWEN-K developed information, education, and communication (IEC) materials in accessible formats for people with hearing impairments. For example, they shared sign language pamphlets in the community and amongst healthcare providers. They also provided basic sign-language and disability sensitisation training to service providers and law enforcers which raised awareness amongst the legal profession of the need to involve a qualified interpreter in court cases. Safe spaces were created for interactive community sessions; people with disabilities were taught about their rights and encouraged to share negative experiences of sexuality. The report stated that through these safe spaces, women learnt that their rights had been violated and became more aware of the need to protect their rights. They also felt more empowered and open to talk about their abuse (92).

FEDWEN-K was successful in creating an enabling environment for people with hearing impairments through advocacy efforts and community awareness sessions targeting women, youth and children with disabilities, parents of children with hearing impairments, law enforcers and healthcare providers. Self-support groups were formed and used as a platform for offering psychosocial, legal and referral support to survivors of gender-based violence. As a result of advocacy efforts, a person with hearing impairment was appointed as a representative of PWDs the Nyeri County Government Health Committee. Lastly, law enforcers in three counties out of the four where the project was implemented passed a policy that required all front office police personnel to learn basic sign language (92).

Forging a district community where women and girls with disabilities live dignified and empowered lives implemented by Lira District Disabled Women Association (LIDDWA), Uganda

In the Northern region of Uganda, WWDs and their families were counselled and trained on being aware of their SRH rights and various forms of GBV and being able to assert their rights. At the same time, healthcare providers were sensitised on the SRHR and needs of women and girls with disabilities. LIDDWA also made sure service providers were held accountable for lack of accommodation that would otherwise prevent access to SRH services for WWDs. Furthermore, LIDDWA partnered with local journalists to ensure health centres who refused to take measures to ensure services were reasonably accommodating to WWDs; their inactions would be publicly denounced. District communities were involved through awareness-raising forums, including husbands of WWDs, community members, law enforcement officers, cultural and religious leaders, and national and local government representatives. These forums were to encourage the key players of the communities would recognise and respect the rights of WWDs. Lastly, they brokered a partnership with legal officers and the National Union of Disabled Persons of Uganda (NUDIPU) to provide legal support for pursuing cases of GBV. The study reports that a change in attitude was seen among police officers as they became more aware and responded better to GBV cases reported by women and girls with disabilities. At the facility level, district hospitals purchased medical equipment to make HIV/AIDS services accessible to WWDs and healthcare providers admitted that WWDs required access to SRH services as much as non-disabled persons did (93)**.**

Peer support networks and village saving, and loan schemes help to address the socio-economic barriers to accessing SRH service implemented by the International Rescue Committee (IRC) and Women's Refugee Committee (WRC)

IRC and WRC in Burundi designed an approach for the integration of GBV services into social and economic empowerment programmes that include WWDs. In the first phase of the project, IRC and WRC conducted a study to identify GBV needs and capacities. This study also identified barriers and enablers to access and inclusion of persons with disabilities. Subsequently, peer supports consisting of refugee WWDs and their caregivers were created. Social protection networks were also created through these peer support groups to expose women to income-generating opportunities and to facilitate access to Village Savings and Loans Associations schemes. The support groups served as a platform for having a series of discussions on GBV issues with caregivers, spouses, and partners (94). According to the programme report, refugee WWDs reported a positive change in their belief. They also said the social protection groups supported their empowerment.

5.1 Increasing Access to Sexual Reproductive Health Services- Outcome 2

Best Wishes for safe motherhood: towards inclusive reproductive healthcare in implemented by Karuna Foundation Nepal (KFN)

KFN launched the best wishes programme in 2015 as a part of Inspire2Care (I2C) Model project which started in 2011 to provide disability-inclusive reproductive health care services. As part of the I2C programme, healthcare providers and female community health volunteers (CHVs) were trained and sensitised on the SRH needs of WWDs. In addition, community awareness and sensitisation programmes were organised to educate the public on sexuality for both people with and without disabilities and dispel myths and misconceptions of disability. Report of impact evaluation (95), showed that during the programme period (2015 - 2019), 202 (78.6%) of respondents mentioned they had a change in perception towards PWDs. For example, they no longer believed karma to be the cause of disabilities and or that WWDs should be refused marriage. Out of them, 97.5% said they saw people in the communities now used disability-friendly words when talking about PWDs. Participants of all five FGDs held with FCHVs, Health Facility Operation and Management Committee and Village Disability Rehabilitation Committee admitted that before the programme, they neglected PWDs because they did not know much about disability (95).

The Best Wishes programme created best wishes cards with basic health information about safe pregnancy and delivery and issued to pregnant women. These cards were also developed in braille, pictograms, and easy language formats to make it accessible for WWDs. As confirmed by a woman with a disability: ***"If the Inspire2Care Program had not come to my village, I would not have known where or how to get antenatal***

check-ups or that institutional delivery really is the safest option. The most important thing I wanted was for my child to be healthy."

In 2017, KFN launched a mobile tracking tool to track data of pregnant WWDs, who visited a health post for the first time. These women were registered and followed-up on to ensure they used antenatal care services, institutional delivery, and post-natal care services. A cases study (92) conducted in 2017 at the same period, the mobile tracking tool was launched, documented that as a result of the innovative mobile tracking system 503 pregnant WWDs had already been registered of whom five had a safe delivery.

Furthermore, 15 health centres were reconstructed and adapted for use by PWDs. Although in general, results showed a change in access to and utilisation of maternal health services in health facilities, for example, institutional delivery as a percentage of reported deliveries, increased from 39% to 72%, it did not indicate what percentage of WWDs out of these figures accessed the facilities.

Lastly, WWDs were recruited as Community Based Rehabilitation (CBR) facilitators and with SRHR training integrated into training for CBRs; they reported that they could now counsel other WWDs sand their families on SRHR and refer them to facilities for the uptake of services. One CBR facilitator stated: ***"I felt comfortable to participate in the training, but I could see that my unmarried friends were blushing and shy. I am now using the knowledge gained in the training to counsel people with disability and their families based on their situations and context."***

5.3 Adapting Information, Education and Communication Material for Use by People with Intellectual Disabilities-Outcome 3

'Her body, her rights': Making Sex Education Work for Young Women with Intellectual Disabilities implemented by Community Based Rehabilitation Network Ethiopia (CBRNE) in partnership with Light for the World (96)

'Her rights, her body' pilot project was launched in 2015 by building the capacity of CBR professionals and CHEWs to target and reach girls with intellectual impairments in four counties in Ethiopia. It also trained parents of girls with intellectual impairments to teach, inform and discuss the topic of sexuality with their daughters. Most importantly, the use of accessible materials and easy to comprehend formats such as posters with colouring, drawings, and text to illustrate SRH messages (as seen in figure 3), and practical demonstration using menstruation pads on dolls. Periodical community dialogues sessions organised allowed boys and girls to raise issues and questions regarding their sexuality.

Figure 3: Picture of adapted IEC Material for girls with intellectual disability (103)

Poster created by the girls during training. The top scene depicts a mother handing her daughter a menstrual pad, which the daughter places. The bottom scene also depict a mother and daughter; the daughter has blood stains on her skirt.

Evidence from the case study report (96) by CBRNE showed that many of the mothers of girls with intellectual disabilities said they were now more aware of how to educate their daughters and their daughters themselves had a better understanding of what happens to their body:

"When she gets her period, she gets very angry, and this training has taught me how to handle that anger, how to help her wash her pant, to change the clean pads and stuff like that. I didn't know how to handle all of that"

Youth Action for Better Health implemented by Leonard Cheshire Zimbabwe (LCZ)

The 'Youth Action for Better Health' project was launched in 2015 to enhance accessibility and inclusiveness of SRH information and services by YPWD to their peers in Zimbabwe. The intervention trained master trainers to become peer-to-peer trainers on SRHR for other adolescents with a disability. LCZ reported that peer-to-peer education was found to have a positive effect on increasing the coverage of SRH information as confirmed by one of the peer educators: ***"I am now confident enough to talk about HIV and AIDS and I can teach others about transmission and protection".*** The programme also created safe spaces in schools as meeting points for YPWD, to openly discuss SRH issues. Partnering with special schools and institutions, sexuality education was integrated into existing school curricula to provide SRH messages to YPWD. IEC materials were adapted and developed into braille, sign language and graphic visual formats. Schools held edutainment programmes such as percussion and traditional dance where SRH information was disseminated. The project report (97) indicated that the intervention was successful. One of the teachers stated that ***"sexuality education helped youths to protect themselves and improve their attitudes and behaviour towards SRHR issues. Unlike in previous years, in the year of implementation, there had not been a single case of unwanted pregnancy among pupils with a disability, which indicates improved autonomy and use of contraception***." A youth with a disability reported that they now practised abstinence or use contraceptives. The project report further highlighted the challenge of lack of skilled providers in SRHR for PWDs. Although while SRHR service providers were trained in disability inclusion indirectly through the trainer-to-trainer activity, it was noted that the project encountered difficulties in tackling the negative attitudes towards PWDs and their sexuality which was often severe in some instances.

Chapter 6- DISCUSSION

The Federal government of Nigeria may have had an increasing role through domestication of international and regional treaties to promote and protect the sexual and reproductive health and rights of PWDs. Nevertheless, existing national legislation, policies and strategies have not adequately integrated the needs of people with disabilities. Within approved statutes, Acts and policies, if the needs of PWDs are not prioritized, or strategies related to addressing the health issues of WWDs are not explicitly highlighted, it is highly unlikely that existing inequities in access to quality SRH services for PWDs can be successfully addressed. WWDs may continue to experience violations of their rights as the chances of implementation and enforcement remain bleak. The inequities in access to quality SRH services for PWDs exist because of other challenges besides the legal and policy environment. Although the challenges for PWDs in accessing SRHR information and services may differ for each individual and may be influenced by the type and severity of the disability, the main central cross-cutting challenges unearthed by this study are the impact of discriminatory socio-cultural norms and beliefs and socio-economic factors. These challenges, as named by most PWDs, can be a consistent and reliable predictor for other factors that influence access to SRHR information and services for PWDs.

A gap exists between people with disabilities' needs for SRH services and their rights to access such services. PWDs have SRH rights that are rooted within the statutes of fundamental human rights. Nevertheless, result findings prove that negative stereotypes resulting from social norms and beliefs undermine the freedom of PWDs to exercise their human and sexual rights as well as their ability to access and use services. The widely accepted religious idea that associate disabilities with “evil or supernatural forces” and the harmful norms regarding PWDs still plays a role in influencing societal attitude, including the attitudes of providers in disability care. In a study by Akasreku et al. (2018) it was shown that if the cause of disabilities were perceived to be spiritual, community members were three times more likely to have a negative attitude and perceptions towards WWDs (76).

According to WHO (2010) (98), the attitudes and behaviours of healthcare providers are influenced by these norms and beliefs which in turn influences the perception of PWD and their willingness to access SRH services. This is line with a finding in urban Pakistan that showed that the majority of women who did not use FP services cited fear of mistreatment as a reason for not using FP services (99). Beyond socio-norms and beliefs, result findings showed that the discriminatory attitudes towards WWDs, as portrayed by some service providers are often associated with a lack of understanding about disability and a lack of capacity in providing SRH services for WWDs. This justifies why interventions implemented by all the organisation listed under outcome 1 and 2 includes efforts to sensitise and build the capacity of service providers to ensure disability-inclusiveness in service provision.

The negative attitude of health care providers towards PWDs has several potential negative consequences on both the healthcare provider and PWDs themselves (100). It will impact negatively on the quality of patient-provider communication. According to Vermeir et al. (2015) (100), poor communication can result in medical mishaps just as highlighted in findings of a WWD been given the wrong prescription. Bear in mind; this could also have been a question of the service providers knowledge and skill. That said, when healthcare providers are labelled as mistreating or misdiagnosing, it may affect their confidence in decision making. It may also most likely affect the patient's experience and trust in the provider. Vermeir et al. (2015) further stated that negative patient experience would lead to the discontinuity of care and worsen health outcomes over time. In terms of the financial implications of poor communication, PWDs may experience delayed treatments and dual diagnosis which may most likely result in incurring double healthcare expenses amidst the already existing challenge of poor socio-economic status.

Results furthered portrayed PWDs as having lesser chances of being highly educated and gainfully employed. Being out of employment and without steady income flow over time, increases the risk of falling into poverty and further reducing the ability to afford healthcare-related costs (101). With some of the findings having demonstrated the cost of transportation and service as a burden to WWDs seeking SRH services, according to WHO (2019), the burden of cost will significantly limit the ability to access and utilise SRH services. Williams and Holmes (2015) (101) opines that healthcare-related cost can be far more challenging for WWDs in rural settings. For example, in rural locations, where health facilities are sparsely distributed, travel time, and distance to available services increases. Without public transport systems well-adapted especially for those with mobility impairments, they would not only have to incur an extra cost with travelling longer and farther away to access services but with opting for suitable transport alternatives. In other words WWDs are plagued with the burden of high travel cost, foregone earnings and cost of care.

Every state has ratified at least one international human rights treaty recognising the right to life; which can only be guaranteed when people have the right to health. Key aspects of these rights include the right to quality health care information and services and accessible physical health facilities (102). Nevertheless, from the result findings, PWDs are denied the rights of health. Facility inaccessibility was one of the significant barriers to accessing services for PWDs, especially for people with mobility problems. With the lack of accessibility to health facilities, PWDs will continue to have an increased dependency on accompanying persons to navigate the health facilities and stand in as communication intermediaries with service providers, which according to Arulogun et al. (2015), compromises privacy and confidentiality of services. The lack of appropriate medical equipment as highlighted by findings limits utilisation of services. Several studies (94,95) showed that many women with mobility impairments were unable to access breast and cervical cancer screening because the examination beds were not height-adjustable. The mammography equipment also only accommodated women who were able to stand.

Results highlights that PWDs typically have inadequate knowledge and awareness of SRH thus indicating that PWDs require access to SRH information and services. However, they face challenges in accessing it with people with visual, hearing, and mental impairments being more at a disadvantage than another disability type due to unavailable sign-interpreters for the hearing impaired; unavailable braille (health information) materials for visually impaired; lack of simple and easy to understand materials /instructions for people with intellectual disabilities (105). For example, a person with visual impairment getting or buying a condom will not be able to find out the expiry dates of condoms unless printed in braille. From professional experience, information, education, and communication materials are produced by SRH organisations in such a way (too small font and no contrast in colours) that it is difficult for people with low vision to read. Besides, they also experience challenges in communicating with service providers.

Furthermore, this study highlights examples of organisations seen to be making or to have made efforts to address such barriers PWDs face in accessing SRH services. From the interventions highlighted, it is essential to note that while tackling attitudinal or institutional barriers, there is also a need to address the environmental barriers faced by WWDs. Beyond removing barriers, an enabling environment needs to be created where PWDs are included in service provision without discrimination. LIDDWA made efforts to ensure health facilities were accessible, especially for PWDs to access SRH services, while they simultaneously challenged the health facility authorities who allowed otherwise. They also brought about changes in the attitude of service providers, communities, and the justice system towards PWDs.

Most interventions found included components of awareness creation, capacity building and sensitisation on SRH and disability. This can be fundamental to changing the mindsets, perceptions, and attitudes of PWDs and society in general. According to Goyal (2017)(94), successful interventions for PWDs often starts with increasing access to information, community dialogues, sensitisation and awareness creation sessions or events amongst PWDs and the society in general. First, and most importantly, a mindset PWDs needs to have a mindset where they value themselves can understand and assert their rights. That way, they feel empowered to not only become self-advocate but to demand and access for SRHR services as when needed. The inclusion of caregivers and communities members, as highlighted in two of the interventions, was crucial to creating an enabling environment where the SRHR rights of PWDs are recognised. As noted by FEDWEN-K, PWDs were now included in the community's health agenda. Besides, it raised an awareness that led to the acceptance of PWDs and a shift in the negative societal attitude and practices.

In addition to interventions that addressed environmental and systemic factors influencing access to SRH services for PWDs, IRC and WRC in Burundi also tried to address the underlying inequalities faced by PWDs through an empowerment and social protection programme. By empowering women and increasing their livelihood opportunities, it can be an effective means of overcoming the socio-economic barriers to access. According to Tolhurst et al. (106) the higher the socio-economic status, the more women have the opportunities to exercise their autonomy and challenge the prevailing norms and misconceptions about WWD and its' influence on their decision making. Therefore interventions that challenge restrictive disability and SRH discourses and at the same time raise awareness on SRH rights and services must take into account the various ways WWDs may require strategic and practical support because this is critical in creating an enabling environment where WWD can better assert their rights.

6.1 Relevance of Conceptual Framework

The challenges as experienced by PWDs are all interconnected and may be more complicated than imagined. However, the use of the Anderson and Newman Model of Health Service Utilization was useful in organising and representing the interrelationship and complexities of the factors that influence access and utilization to SRH services for PWDs. It was also useful in organising the various entry points for addressing the barriers to access. However, there may be a need to expand the scope of the original model and develop a guided framework to incorporate sub-factors such as geographical location (urban-rural settlement) and socio-demographic characteristics of a community as influencing factors to healthcare utilization. These are also essential determinants of healthcare utilization. The full model includes determinants such as health-related practices, client satisfaction, perceived quality of care and evaluated health status. These factors though necessary can be quite complex and challenging to measure.

6.2 Strength and Limitations of the Study

There are no reliable, up-to-date national statistics available on disability prevalence in Nigeria; available estimates vary for the number of PWDs in Nigeria. Therefore, any inference on the extent of the impact of the inaccessibility of SRH services to the population of PWDs, one would need to consider the reliability of these statistics on disability prevalence in the country. Studies conducted in Nigerian on access to SRH health services for PWDs were also found to be extremely limited in number. Besides, the reliability of some of the evidence found, especially those from LMICs, was questionable as they failed to describe the methodological approach in details. This also in agreement with findings from the London School of Hygiene and Tropical Medicine (LSHTM). When several studies conducted in LMICs on people with disabilities from 2000 to 2018 were assessed, they found very few studies from LMICs. Also, two-third of primary studies assessed were graded as low quality with methodological problems. The systematic reviews were generally of good quality; however, less than one-third qualified as high quality (91).

Differences in access to SRH services may also vary significantly by disability type and severity, level of support needed, and service provider type accessed. However, no study was found that made such disaggregation; most available evidence instead focused on access for people with a specific disability type. This study, therefore, in some instances, had to apply estimates uniformly for all people with disabilities and generalise findings to PWDs of all ages and disability types. Studies lacked evidence on where the health needs of PWDs are mostly met. One striking observation was a rarity of studies carried out in the eastern part of Nigeria due to the geographical focus of most donors in the country which happens to be in Northern and Western parts. Nigeria is a culturally diverse country with dissimilarities in practices that could also affect access to SRH services or how PWDs perceives the difficulties with access. The studies found on effective interventions to overcome the barriers faced by PWDs were those conducted particularly in Eastern and Southern Africa and Asia, thus, highlighting an evidence gap on studies from Northern and Western Africa. Most intervention studies found were not empirically tested or simply did not provide enough detail to assess their strengths and weaknesses. Besides, they were mostly Case studies conducted by NGOs, which typically scores lower on quality rating according to Monteath-van Dok (2020) (94).

It is essential to note in general that although qualitative studies may be limited by their inability to be generalisable, they were useful in providing insights into the challenges of PWDs in Nigeria experience that influences their ability to access SRH services.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

Literature findings demonstrate the existence of challenges with access to sexual reproductive health services for PWDs. The lack of understanding and awareness of disability in relation to SRH was an overarching challenge that reinforced all other barriers such as the harmful and discriminatory practices often resulting in exclusion or denial of both justice and healthcare services to PWDs. Access to SRHR services is a challenge for PWDs due to the inaccessibility of health facilities. Bear in mind that accessibility is beyond physical infrastructure. It includes having adequately skilled providers in disability inclusion, well-adapted medical equipment, information, education, and communication materials in appropriate formats. In the majority of the example's of interventions discussed, as part of every programme component, the focus was making information more accessible and improving communication between PWDs and service providers. Information and communication barriers can be a significant obstacle beyond healthcare for PWDs, especially when the support looked for is linked to the justice system.

Advocacy efforts are also required for effective enforcement of laws and policies necessary to ensure accessibility to SRHR services. Awareness creation on disability among decision-makers and communities is paramount to creating an enabling environment where PWDs are included without discrimination. Furthermore, in order to increase the involvement and commitment of communities and government, capacity-building is mainly required to ensure address disability-inclusiveness on all front.

Conclusively, it is also imperative to note that due to the multiple barriers PWDs face and the various types of impairment, interventions require a multi-prong approach just as concerted efforts of the education, media, justice and legal system are also required. Braathen (2016) (107) explained on the topic of disability and HIV "it is crucial to consider the interconnectedness of the challenges faced by an individual and a household. Issues of health (physical and mental), disability, employment, education, infrastructure (transport/terrain) and poverty are all related and interconnected and should be addressed to secure equity in health."

7.2 Recommendations

This section summaries concrete recommendations for action:

Recommendation for Programme

- Donor agencies should build and invest in partnerships and coalitions. International NGOs should partner with local NGOs and the national Disability association to design and implement disability-inclusive interventions.
- FMoH and SRH organisations should work in partnership with media organisations to raise the awareness of communities on disability and SRHR of PWDs. Ensure PWDs are visible and well-represented in public agenda such as National agenda, communities health programmes and research agenda.
- NGOs should engage with religious and traditional leaders as change-makers and disability advocates. More sensitization programmes should also be organised by SRH and disability experts in local communities to educate the public about the SRHR of WWDs to overcome the discriminatory attitude of communities and providers
- SRHR organisations should ensure that IEC materials are adapted into accessible formats and tailored to the needs of PWDs. At the same time, the IEC materials should also be inclusive of or accessible to PWDs with intellectual disabilities.

- SRH organisations should adopt the ‘twin-track’ approach_ mainstreaming disability into existing programmes and using disability-specific programmes when needed.
- The Federal Ministry of Women Affairs and Social Development (FMWSD) in collaboration with the Ministry of Education should ensure that comprehensive sexuality education is integrated into the curriculum of special needs schools.

Recommendation for Policy

- Policymakers should ensure the inclusion of women and girls with disabilities in legal and policy frameworks. Policymakers should also take deliberate actions to make budgetary allocations for modification of facilities to ensure the availability of proper infrastructural facilities that are disability-friendly such as ramps, and assistive devices.
- Policymakers need to ensure training for SRH providers includes training on the SRHR of WWDs to ensure SRH services that are responsive to their needs.

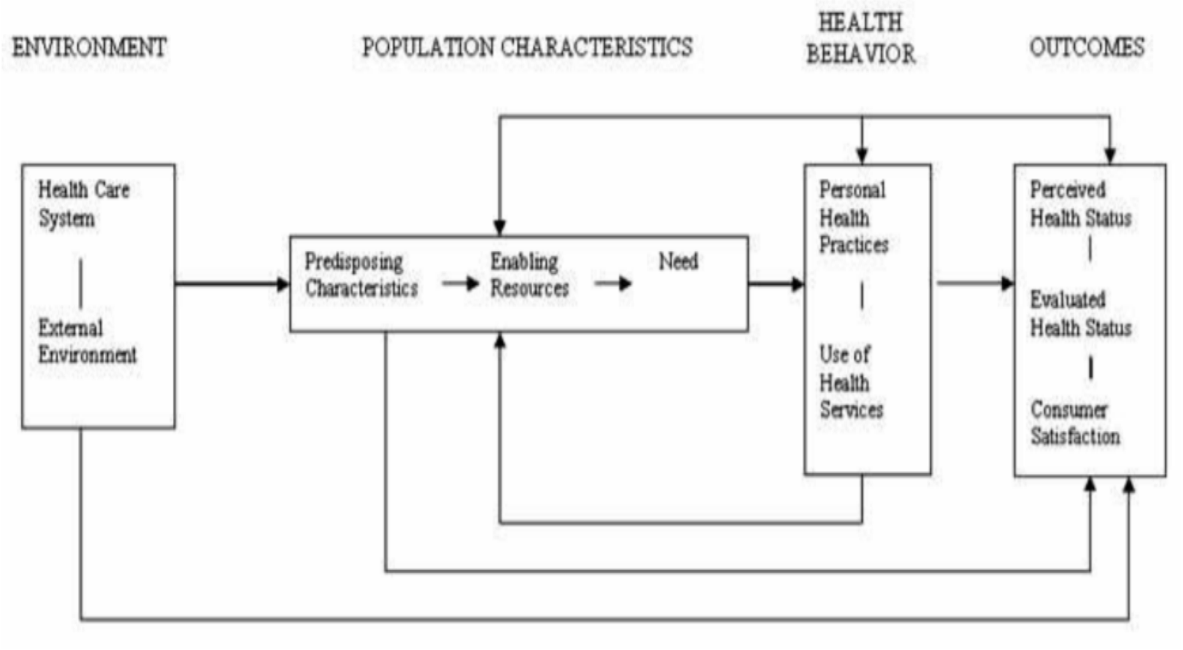
Recommendation for Research

FMWSD, NGOs, research institutes, JONAPWD and donor agencies need to develop more robust research evidence on the SRHR needs of PWDs either by promoting or funding. The research evidence can enhance awareness creation and advocacy efforts to influence decision-makers, and stakeholders to adopt or invest in interventions to address the SRH needs of PWDs. Additionally, research should include PWDs right from the research design phase and throughout every stage.

Annex 1: Search Table Keywords

	Keywords
SRH Topics	Access, Sexuality, Sexual Health, Reproductive Health, Service Utilization, Young People with Disabilities, Women with Disabilities, People with Disabilities, Maternal Health Services, Influencing Factors, Negative Attitude, Stigmatisation and Discrimination Socio-cultural norms, Gender-based Violence, HIV, National Health Policies
	MESH Terms
	“Sexual Health” OR "Reproductive Health” OR “Reproductive Health Service” OR “Maternal Health” OR “HIV/AIDS” OR “Sexual Transmitted Infection” OR “STI” OR “Family Planning” OR “Sexuality” OR “Health Education” AND “Disability” OR “Disabled persons.”
Interventions	“Sexual Health” OR "Reproductive Health” OR “Health Services Accessibility” OR “Health Services Needs and Demand” OR “Organisation.” OR “Interventions” OR “Best Practices” AND “Disabled persons” AND “Country.”

Annex 2: Anderson and Newman Model of Health Service Utilization



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