SEXUAL AND REPRODUCTIVE HEALTH AND RIGTH OF PEOPLE WITH PSYCHOSOCIAL DISABILITY IN NIGERA: FACTORS AFFECTING ACCESS AND UTILIZATIONOF SERVICE

Master of Science in Public Health- September 17, 2018- September 05, 2019

ROYAL TROPICAL INSTITUTE (KIT)
Vrije Universiteit Amsterdam

Royal Tropical Institute

VU VRIJE UNIVERSITEIT AMSTERDAM

A thesis submitted in partial fulfilment of the requirement for the degree of Master in Public Health (MPH)

By

Ibrahim Muhammad Usman

Nigeria

Declaration: Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with the requirements of institutes. The thesis "Sexual and Reproductive Health and Right of People with Psychosocial Disability in Nigeria: Factors Affecting Access and Utilizations of Services is my own work.

Signature:

55th Master of Science in Public Health/International Course in Health Development

17th September 2018 – 05 September 2019

KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2019

Organised by:

KIT (Royal Tropical Institute) Health Unit Amsterdam,

The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)

Amsterdam, The Netherlands

Contents

List of Abbreviations

AIDS	Acquire Immune Deficiency Syndrome
ART	Anti Retro Viral Therapy
BCC	Behaviour Change Communication
CBHWs	Community- Based Health Workers
CEDAW	Convention on Elimination of All of Discrimination against Women
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DALYs	Disability Adjusted Life Years
DHO	District Health Offices
EmOC	Emergency Obstetric Care
FBO	Faith Based Organization
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
FP	Family Planning
FP2020	Family Planning Goal 2020
FSW	Female Sex Worker
GFF	Global Financing Facility
HCs	Health Centres
HFs	Health Facilities
HIV	Human Immune Virus
HUs	Health Units
HWs	Health Workers
IBBS	Integrated Biological and Behaviour Surveillance
ICPD	International Conference on Population and Development
ICPD+5	United Nation General Assembly on ICPD review after five years
IDPS	Internally Displaced Persons
IDUs	Intravenous Drug Users
IECs	Information, Education and Communication
IMNCH	Integrated Maternal, Newborn and Child Health
IMNCAH+N	IMNCH and Adolescent Health+ Nutrition
LGA	Local Government Authority
MCH	Maternal and Child Health Care
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio

NARHS	National HIV/AID and Reproductive Health Survey
NBS	National Bureau for Statistics
NDHS	National Demography and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NGOs	Non- Governmental Organizations
NHA	National Health Account
NHIS	National Health Insurance Scheme
NPOPC	National Population Commission
NRHWG	National Reproductive Health Working Group
PMTCT	Prevention of Mother-to-Child Transmission
PWD	Persons with Disability
PSSD	People with Psychosocial Disability
RH	Reproductive Health
SMoH	State Ministry of Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rates
UNFPA	United Nations Population Funds
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization

Glossary

Disability can affect the way a person uses their body or brain, as well as or their ability to do things in their environment. A disability can be a:

- Sensory disability like being deaf
- Physical disability like a spinal cord injury
- Intellectual disability where people have learning difficulty, or
- Psychosocial disability from a mental health condition.

Psychosocial disability: means the way of thinking, feeling and interaction with other people is limited by barriers to that stop the affected person from fully participating in the activities of life. There are two type of disability related that are to mental health condition:

1. **Psychosocial disability** (based on the social model); the term comes from the United Nations Convention on the Rights of Persons with Disabilities. This is a convention about human rights of people living with disabilities. Psychosocial refers to interaction between: Psychology (e.g. understanding, experiences, emotions and feelings) and Social (how mental health difficulties or people experiencing mental health difficulties are viewed by others and what are the societal values or culture understanding related to it). Psychosocial disability is mostly related to social and economic consequences of mental health condition. It define by the ability earn money; to address needs and develop social network. It is used to describe the challenges or limitation a person with mental health condition experiences in life. These challenges, limits and impairments are seen as disabilities that can influence person's ability to participate fully in life (3).
2. **Psychiatric disability** (based on the medical model); the term mostly focuses on the impacts and treatments of symptoms related to mental health conditions (3).

Child marriage: The marriage of a girl or boy before the age of 18 and refers to both formal marriages and informal unions in which children under the age of 18 live with a partner as if married. It affects both girls and boys, but it affects girls disproportionately (8).

Maternal Mortality ratio (MMR): The number of maternal deaths per 100 000 live births (8).

Maternal mortality: The death of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (8).

List of Figures and tables

Acknowledgement

All Praise, salutation and gratitude to ALLAH (S.W.A) the creator of the universe, I thank Him for the gift of life and good health without which I wouldn't have come to this level in my life.

Salutations and love to prophet Muhammad (S.A.W), His family and the companion of Islam.

Prayers to my late Fathe,r Alh Mamman kyabe (Mai farin gida) and my mother for a wonderful upbringing which has been a driving force in my journey through the life, May ALLAH give you jannah.

Grateful to royal dutch kingdom of Netherlands and the Nuffic for this rare opportunity, I will remain ever grateful.

Deep sense of appreciation to the management of Royal tropical institutes, the coordinator and advisors of ICHD program and the secretariat for this wonderful opportunity, without your support I wouldn't have come here.

More appreciation to my course academic advisor, thesis advisor and thesis academic advisor for their untiring support, guidance, encouragements and advices. I found your guidance always useful and helpful.

Love to my wife, daughter and member of my extend family, without your moral support and prayers it would not have been this good.

To my colleagues, I am very proud to be one of you.

Abstract:

Mental disorders and it various outcomes like psychosocial disability are among the global priority for non-communicable diseases. In Nigeria about 10% of common mental disorders like depression and anxiety lead to psychosocial disability. However their access to opportunities especially SRHR care is limited due to socio-economic, cultural and institutional barriers. This has led to worsening health conditions, deaths, loss of economic productivity and violation of fundamental human rights. A report from Nigeria shows only 3% of government allocation for health is been earmarked for mental and psychosocial care, and only 10% of all people with mental health problems have access to health care services in Nigeria including SRHR services.

Objectives:

To explore factors affecting access and utilization of SRHR services for PSSD in Nigeria, in order to make recommendations, advocate for policy change and suggest effective intervention that will enhance their access and utilization of SRHR services

Methods:

The study derived information from literature review in the published and unpublished scientific studies regarding SRHR and PSSD in Nigeria and in similar context.

Findings:

Findings in the different literatures and from various contexts used in this review shows influence of policy, laws, socio-economic, cultural and beliefs on access and utilization of SRHR service for PSSD in Nigeria.

Recommendations:

Government and key stakeholders including the communities should work together overcome the barriers and promote enablers of access and utilization of SRHR services for PSSD.

Keywords:

"Sexual and Reproductive Health and Right" "Access and Utilization" Enablers and Barriers" "Psychosocial Disability"

Words count: 12,926

Introduction

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (8).Mental Health involves a combination of the physical, intellectual and cognitive state of an individual, stable enough to handle the stress of life, or make meaningful contribution in the society (1, 3). Sexual and reproductive health and rights (SRHR) comprises the state of physical, mental and social wellbeing in relationship to sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity (1).A sound mental and sexual and reproductive health is therefore global public good and key element for achieving sustainable development of any country irrespective of the economic viability. It helps to define the socio-economic and environmental potential of individuals, communities and the societies (1, 2 and 8)**.** These two concepts (Mental health and SRHR) can have influence on each other and can also affect productivity of people in the society (2). In an ideal situation design of SRHR intervention is therefore done in such a way that all the components of SRHR are included and addressed, in order to ensure full access and utilization of such services (3). As fundamental human rights, SRHR also give individuals the opportunity to decide on their reproductive life, sexual behaviour and orientations free of stigma, discrimination and coercion, in regard of the circumstances around the physical or mental state of that person (8). Components of SRHR are; Gender-based violence, HIV/AIDS and other STIs, Contraception, Maternal and newborn health, Abortion, Infertility, Reproductive cancers (8).

Barriers and enablers such as socio-economic, socio-cultural, behavioural, biomedical and institutional factors are found to affect access and utilization of health services, especially SRHR and mental health services in Nigeria (5, 9). Provision of basic SRHR, Mental health and psychosocial services are associated with number of challenges in Nigeria due to scarcity of human and material resources for health (6). In addition, Health needs including SRHR and mental health services are not uniform across populations. For example persons with psychosocial disability (PSSD) often require more attention or service due to impairment in cognitive, intellectual or learning ability (7). They also encounter some specific barriers that hinder their access to mainstream health service which worsened their health conditions (7, 9). These barriers are linked to certain factors, hence it is necessary to identify those factors, their influence, dynamics and effect on access and utilizations of SRHR services for vulnerable groups in the society like the PSSD (3, 5).Moreover, the PSSD are among the most common victims of sexual abuse, gender based violence and their rights to sexual and reproductive health are often overlooked and neglected in most developing countries (6).

During the six year of my clinical practice, I also observed that people with PSSD like any other person have SRHR needs like family planning, delivery and menstruation care, but addressing their needs in the mainstream health system was always associated with serious challenges. Among the common challenges that I noticed include; lack of adequate funding by hospitals, cost of care, cultural beliefs, misinformation and faiths.

This thesis therefore is a literature reviewing on factors affecting access and utilization of SRHR services among PSSD in Nigeria and its similar context. Effective strategies to promote access of SRHR services, policies and laws are identified and discussed. The thesis was concluded with recommendations to government and relevant stakeholders in Nigeria

The thesis is divided into six chapters; chapter 1 provides summary on the background information about demography and health and social context in Nigeria. In chapter 2 the

problem affecting PSSD and possible outcomes in Nigeria are presented, this followed by the justification, objectives and the conceptual framework used. Subsequently Health policies, Laws and SRHR gaps are presented in chapter 3, chapter 4 present enablers and barriers for access and utilization of SRHR service among people with PSSD. In addition, chapter 4 also presents findings on available interventions for promoting access and utilization of SRHR service for PSSD from other Nigeria and other context. Discussion and limitation are presented in chapter 5, while conclusions and recommendations are presented in chapter 6.

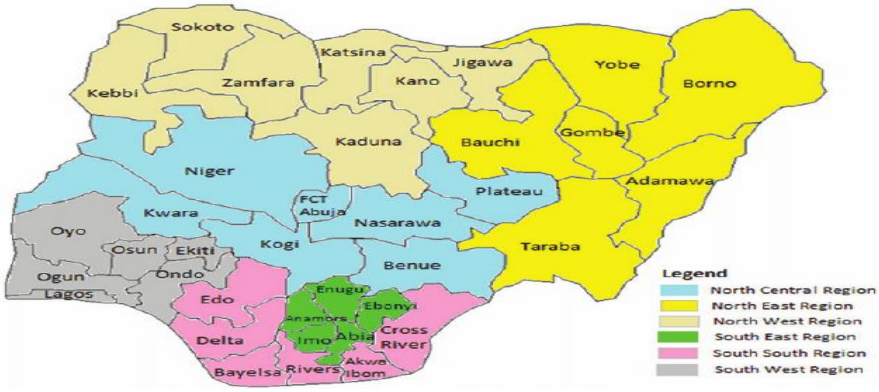
1. Chapter One

This chapter provides background information about the demography, health and social context relevant to people with psychosocial disability (PSSD) in Nigeria

1.1 Geographical Background

Nigeria is a country with abundant resources and huge potential; located on the west coast of Africa (12). Nigeria is boarded Atlantic Ocean to the south, the republic of Cameroon to the east, and the republics of Chad and Niger in the north and the republic of Benin in the west (11). Nigeria was ranked as the fourteenth largest country in landmass in Africa and thirty-two largest in the world, with the total of 351,648 sq miles/923,768 sq km2 of land (36).

Figure 1: Map of Nigeria (36)

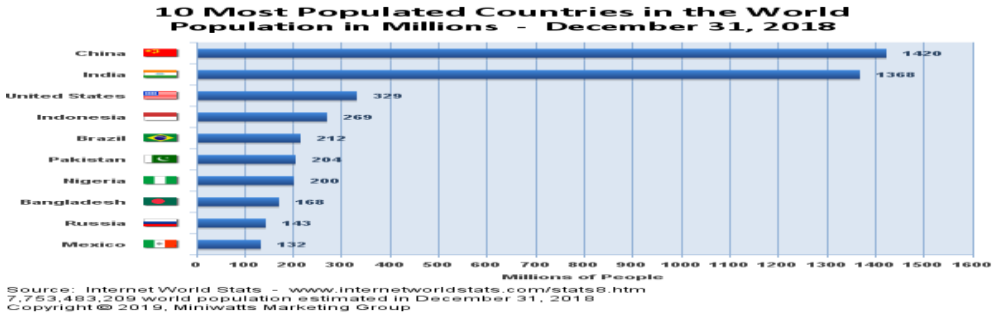


Source: map of Nigeria. Geology.com

1.2 Population

According to the reports of the world population estimate in 2018, Nigeria was ranked 7th most populated country in world and first in Africa, with total population of slightly above 200 million people (see figure 2) (69). The country has about 371 ethnic groups, predominant ethnics groups are the Hausa, Igbo and Yoruba. The population is also diverse in religious beliefs; about 50% of the population is Muslim and about 40% Christian, while remaining 10% practices traditional religions. The north of Nigeria is predominantly Hausa-Fulani Muslim, while in the south they are largely Yoruba and Igbo Christians. Nigeria has relatively high population of young people (62%) of age 25 and below, the average median age is 18.4 years. Over half of the total population (51%) lives in rural areas (11, 69).

Figure 2: 10 Most Populated countries in the world (11)



1.3 Administrative profile

Nigeria operates a federal system of government and is divided into 6 geopolitical zones (figure 1) and has 36 states and a Federal Capital Territory (FCT). Each state is further divided into smaller administrative units called Local Government Area (LGAs) (69). There are 3 administrative arms of government in Nigeria; 1- Executive headed by the President at the national level, the Governors in the states and Chairmen in the LGAs, 2- Legislative arms is comprises of national and state assemblies, 3- Judiciary made up of panel and shari'a courts (69).

1.4 Economic status

Nigeria has been classified by World Bank as a low middle income country with a gross domestic product of 2% ($375,745 Billion). Nigeria's economy mainly depend on oil revenue and have not been stable due to the instability of global oil market; thus, the gross domestic product (GDP) growth rate is highly variable (69). For example, it was as high as 8% in 2006 but dropped to 1.5% in 2016, which is due to global fall in oil prices in 2015 and as a result to economic recession in the country. However, the recovery in oil prices 2 years ago has positive impact on GDP (11). About 62% of the population in Nigeria is still living in extreme poverty due to social inequality. Poor states of infrastructure, insecurity, regulations, restrictive trade and corruption are the major economic challenges in the country (69). The present administration has prioritized transparency, fight against corruption and increase investment in agriculture through private partnerships. Through this efforts Nigeria was able recover looted fund, redeemed the country's image in the internationally community and raises developmental indices (108).

1.5 Education Status

Around 38% of women and 21% of men age 15-49 have no formal education in Nigeria. Records from NDHS indicated that only about 17% of women and men in Nigeria are educated to primary school level. Around 36% of women and 49% of men attended secondary school. In addition, only 10% of women and 14% of men have post secondary school education. People living in the urban areas achieved higher levels of education than those in rural areas (4).

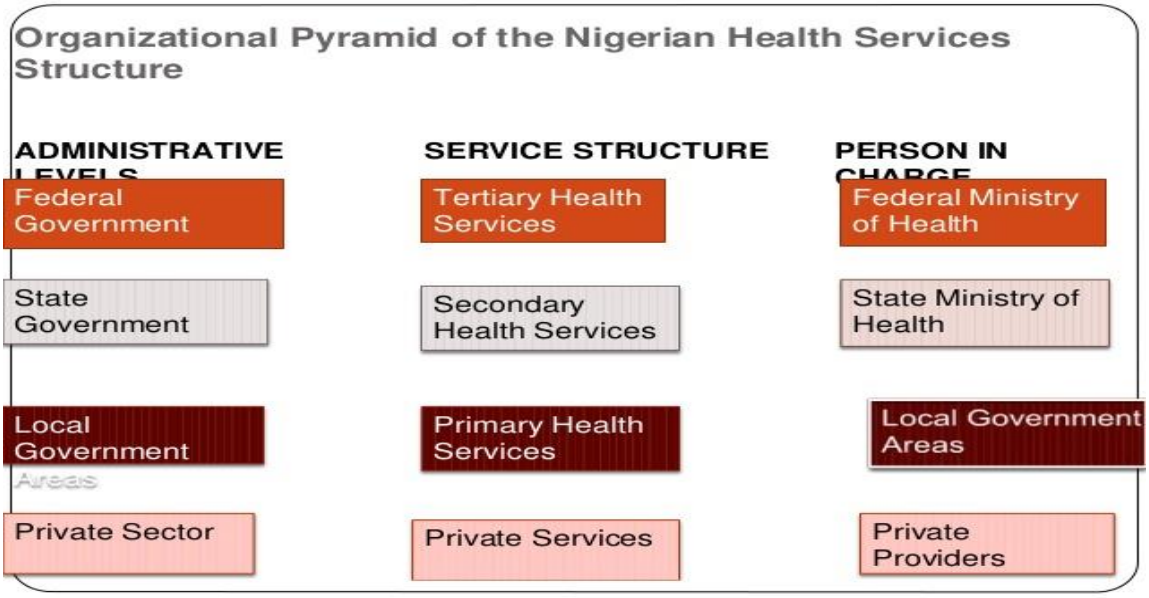
1.6 Overview of Health System in Nigeria

The health system in Nigeria is decentralized, health care is provided at three different levels; primary, secondary and tertiary (6). The primary levels are mainly responsible for health prevention, promotion and treatment of common ailments. They also served as the entry points into the health care system and they are largely under the responsibility of the Local government areas with some support from the Federal and State Ministries of health (6, 67). The secondary levels provide specialized care to patients referred from the primary level and is mainly the responsibility of the State Governments (6, 67). The tertiary levels provide highly specialized care and they are under the responsibility of the Federal government (6, 67). However, overlaps can occur within the three different level of health care. Private sector (For profit and non for profit) as well as faith based organizations are found within these three levels of care (6, 69).

Health facilities at primary level in Nigeria include; health posts, health centres, dispensaries and clinics. And the personals at primary level are mainly midwives, nurses, community health officers, community health extension workers (CHEWS) and environmental health officers (36). In the secondary level, health facilities are the general hospitals and personals are mainly medical doctors, pharmacists, nurses,

midwives, medical laboratory scientist, radiographers and records officers (36). The tertiary level made up of the highest health care in Nigeria, it consists of highly specialized care and the largest health care workforce in Nigeria (36).Community health extension workers (CHEWs) who work mainly at the primary care level are trained for 2-3years. Nurses/midwives and doctors that provide secondary and tertiary SRHR service in Nigeria are trained for 3 years and 6 years respectively (6).

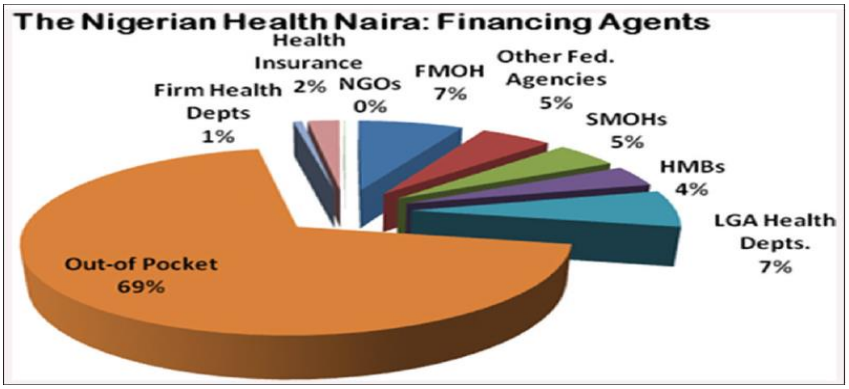
Figure 3: Health System Levels in Nigeria (36)



Source: Federal Republic of Nigeria: Country Report, 2018.

Health care services are generally underserved in Nigeria. For example, the PHC covers less than 30% of the people who are potentially in need of those services (69). The situation is worse for SRHR services because basic health care services for prevention and treatment of common ailments are not readily available (6). For example antenatal care (ANC), services for prevention of mother to child transmission of HIV (PMTCT), essential drugs and adolescent-friendly services are available in only about 5% - 10% of the PHCs (9). Government health expenditure in Nigeria is $8 per capita which is unacceptably low in comparison with internationally recommended figure of the $ 34 (6). Although health insurance was introduced since 1999 but currently only about 2 % of the total populations are in the insurance system. Despite this high rate of poverty, there is also high out of pocket expenditure (78%) which increases the risks of financial hardships on individuals and families (6).

Figure 4: Government Health Expenditure in Nigeria (101)



Source: National Health Account of Nigeria, 2017

1.6.1 Overview of Sexual and Reproductive Health Profile of Nigeria

Sexual and reproductive health and rights (SRHR) problems affecting vulnerable population such as adolescent and people with disabilities including PSSD remain major issue of public health concerns in Nigeria (10). This is due to rapid population growth, increasing incidence of sexually transmitted diseases and HIV/AIDS. Other challenges include high rate of teenage pregnancy, unintended pregnancy and unsafe abortion as well as high maternal mortality (9). As highlighted in demography, Nigeria is one of the fastest growing populations in the world. Current population growth rate is 3.2%, and more than 60% of the total population of reproductive age (15-49 years) (4). Although available statistics indicated a slight improvement in the reproductive health patterns in Nigeria, going by the current population growth rates, Nigeria will likely double the size of its population (400 million) by the year 2050 (12). Reproductive health indicators have always indicate high morbidity and mortality from pregnancy and child birth related causes from Nigeria (14).

In addition, about 9 million pregnancies are recorded in Nigeria annually, and one out of 13 pregnant women died from an avoidable cause related to pregnancy or childbirth (16). The Maternal Mortality Ratio (MMR) is 565 deaths per 100,000 live births on average but much higher in northern parts of the country (800 deaths per 100,000 live births in 2015) (13). In 2017, a total of 58,000 maternal deaths occurred in Nigeria which was 19% of the global maternal mortality (36). Young girls are also very vulnerable to harm practices and sexual right violation like early/child/forced marriage, rape, sexual coercion and sex trafficking (16).The teenage pregnancy rate is 23% among women aged 15-19 years in 2017 and about 1.25 million induced abortions occurred annually (13). HIV prevalence among adults aged 15–49 years is 1.4% and more than 3 million people are living with HIV/AIDS but only about 30% of the infected persons are receiving antiretroviral (ART) treatment in Nigeria (10). Additionally, more than 86% of women and girls of reproductive age have no access to modern methods of family planning in Nigeria and only 31% of deliveries took place within health facilities (10).

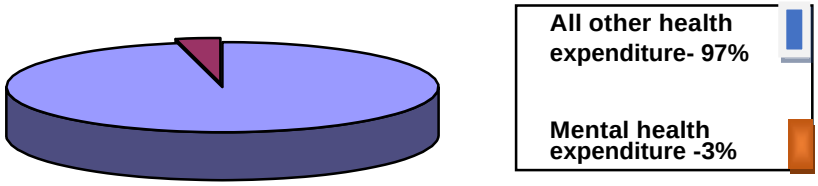
1.6.2. Overview of Mental Health and Disability Profile of Nigeria

Disability from psychosocial cause can have major impact on the quality of life and socio-economic wellbeing of individuals, families and the societies. Around the world, one out of 5 persons with disability is due to psychosocial causes (2). Large numbers of PSSD are living with lifelong impairment that requires lifelong care. Psychosocial disability is among the prioritized non-communicable diseases that is receiving global attention (34). Report from Nigeria has indicated the role of psychosocial disability in worsening health conditions, causing death and leading to loss of economic productivity (35). In addition, about 10% of common mental disorders like depression and anxiety lead to psychosocial disability in Nigeria (7). Furthermore, depression is a common mental disorder in Nigeria especially among women and elderly population; this disorder contributes to increasing number of PSSD population in Nigeria (23). For example, about 7% of elderly people with depression in Nigeria develop psychosocial disability within the first 12-months period and up to 25% of people above the age of 65 years, who are diagnosed with depression, will develop disability in their lifetime (21). Mental health services and psychosocial support are mainly provided by the government in the secondary and tertiary care levels, these facilities are mostly located in the big cities in Nigeria (7). Access to mental health services and psychosocial support is very limited for a large population of Nigeria especially in rural communities (16).

Currently, there are only about 200 trained psychiatrists presently living in Nigeria, this means that the ratio of psychiatrist to patient in Nigeria is around 1 per 1 million

populations. The ratio of psychiatric nurses to patients is around 5 per 100,000 populations. Other mental and psychosocial health professionals like clinical psychologists, social workers physiotherapists and occupational therapists are also underserved (6). Support systems for ensuring good mental health service delivery like availability of psychotropic drugs, integration of care, health information systems and referral are weak and poorly coordinated (6). Reports show that only about 3% of government allocation for health is been earmark for mental and psychosocial services and only 10% of all people with mental health problems have access to health care services in Nigeria including SRHR services (7).

Figure 5: Mental Health Expenditure in Nigeria



2. Chapter Two

2.1. Problem statement and study justification

Over the past decades efforts have been intensified by the global community to improve the provision of SRHR services, the main aim is to ensure equitable access those services particularly for vulnerable groups (1). Although remarkable progress has been achieved, but ensuring full access and utilization of SRHR services for vulnerable groups like PSSD is still a serious challenge(8). Recent estimates show that only 20% of global populations of PSSD have access to SRHR services (83)

As described in the background, Nigeria has a large young population of 25 years and below (4). Although no available evidence to show age distribution of PSSD in Nigeria, but with the large number of young population in the country, majority of PSSD in Nigeria are also likely to be within reproductive age group (15 -49 years) and are sexually active (5). In Nigeria, PSSD are also common victims of sexual abuses and other forms of gender based violence, they are three times more at risks than persons with no mental health problem (25). Sex through abuse is mostly unprotected and sometime may involve more than one person, this increases the risks of STIs/HIV, unintended pregnancy and reproductive health problems that may arise from pregnancy and child birth (20).

Generally, people with disabilities including the PSSD have identified as priority group for SRHR care in the policy document of Nigeria (36).However, their requirement for SRHR care and specific needs are different from that of the general population (69). Studies show that young PSSD with learning difficulties have risks of SRHR problems due to lack of awareness. Information asymmetry can create communication gaps especially in areas of comprehensive sexuality education, counselling service for STIs/HIV and screening reproductive cancers, which may affect their access and utilizations to SRHR service (44). Available data about SRHR services (contraception, STI/HIV prevention and treatment and testing services in the voluntary counselling and testing centres) in Nigeria is based on the survey conducted since 2007 which is about two decade ago (9). Even in that report, access to SRHR services especially among adolescent and the PSSD has been found to be grossly inadequate and far below the minimum acceptable level recommended in international guidelines (9). Although no recent survey is conducted to overview the information, the current situation is expected to be worse due to deteriorating conditions of the economy and health infrastructure in the country (10).

Mind-set and attitude of people (at policy and service delivery level) towards PSSD have been found to affect their access to SRHR services in Nigeria (76). For example, it is well known assumptions in Nigeria that PSSD are a-sexual or not capable of marriage and child bearing which can be responsible for their frequent omission in the SRHR information in the country. This information is used to make decisions including policies and intervention to be implemented (14). Support from friends and families of PSSD can be affected by attitude of community toward psychosocial disability (21). Stigma and discrimination in the communities regarding SRHR services (family planning and contraceptive) also affect access and utilization of such service (58). For PSSD in Nigeria, access to SRHR services is more difficult because of double stigma (16).

Privacy and confidentiality issues regarding SRHR for PSSD are another major barriers affecting access and utilization of those services (20). Traditionally in Nigeria, during counselling or screening sessions, a family member of a PSSD have to be present in most health facilities, this makes access and utilization of SRHR services in PSSD to be highly dependent on availability and understanding of these family members (15).

Information given to those family members can be interpreted wrongly, and can be used to make decision about the SRHR care of PSSD (20). In addition, health information given to family members in Nigeria, are used based on personal knowledge, perceptions choices and relationships with person having the disability, which consequently affect access and utilization of SRHR services (16). These challenges can be attributed to social-cultural and institutional barriers, which have affected the distribution and access of SRHR services, education and behaviour change programs (18).

2.2. Justification

National health policy of Nigeria was reviewed in 2016, and provision of SRHR services to vulnerable groups was among the key priority areas with the sole aim of addressing health gaps in the country (10). Most of the solutions proposed are centred on economic empowerment, poverty reduction and increasing access to SRHR information and service for women and girls of reproductive age group (10). Although people with disability are among the high priority group, current SRHR intervention and programs in Nigeria are still not readily available and accessible to them (81). People with disabilities including those with physical, psychosocial, intellectual and sensory impairment have specific SRHR requirements different from that of the general population (34). However, this thesis is focusing mainly on PSSD

Information about knowledge, attitudes and perceptions of the community regarding access and utilization of SRHR service for PSSD is very limited in Nigeria, and that can affect health policies and strategies of government to address the specific SRHR needs of PSSD in the country (15). This information is required to understand the dynamics of factors affecting access and utilization of SRHR service for PSSD in Nigeria (21). The information can also be used to advocate for policy change and suggest effective interventional approach using evidence (10).

A number of quantitative studies have discussed risks and burden of the SRHR problems of PSSD in Nigeria. Fewer studies focus on analyzing factors affecting access and utilization of SRHR services for PSSD in Nigeria. This thesis therefore aims to address knowledge gaps regarding barriers and facilitators of access and utilization of SRHR services of PSSD in Nigeria. Findings from this study will be used to make recommendations and advocate for policy change and interventional improvement.

2.3. Research Objective

2.3.1. Overall objective

To explore factors affecting access and utilization of SRHR services for PSSD in Nigeria, in order to make recommendations, advocate for policy change and suggest effective intervention that will enhance their access and utilization of SRHR services

2.3.2. Specific objectives

1- To review the current national health policy, laws and identified gaps in SRHR care for PSSD in Nigeria.
2- To identify and describe facilitators and barriers of access and utilization of SRHR services for PSSD in Nigeria.
3- To identity and describe interventions for access and utilization of SRHR services in Nigeria and from countries outside Nigeria.
4- To make recommendations to relevant actors (Government, community &NGO) for policies and interventional change that will improve access and utilization of SRHR care among PSSD in Nigeria.

2.4. Methodology

2.4.1. Study design:

The study derived information from literature review in the published and unpublished scientific studies regarding SRHR and PSSD in Nigeria and in similar context. Reports (published and unpublished) about the SRHR policies, protocols and interventions by the government and relevant stakeholders were used. Information regarding the type of SRHR service available in Nigeria, the common SRHR issues for PSSD in Nigeria and similar context are identified and reviewed.

2.4.2. Study design:

Search engines and data base like Google, Google Scholar and Pubmed Vrije Universiteit online library were used to access relevant document. Reports, Guideline and Journals of local and international agencies are obtained from the website of relevant Government and international agencies like the Federal Republic of Nigeria (FGON), Federal Ministry of Health of Nigeria (FMOH), Federal Ministry of Women Affairs and Social Development, World Health Organization (WHO), World Bank Group, United Nation Population Funds (UNFPA), Alan Guttmacher Institute, Family Health International, and Engender health and the International Disability Alliance website. To enrich the study additional information are obtained about access and utilization of PSSD to SRHR care from other countries. Literatures used include; Published peer reviewed and grey literature using key words and References followed up published between 2000 and 2019. Delimiters were English language. (See annex 1).

2.4.3. Conceptual Framework:

Andersen-Newman behaviour model for access to health services was considered for this study because the framework can be use analyze factors affecting of health services utilization based on predisposing factors, enabling factors and external environment in which the seeking of health care took place. In addition, the framework can also be use analyze individual factors which is based on personal's knowledge, choice and preferences to seek for health care, which is referred to as needs in this framework (26). Major limitation is that the framework is not explicit and consistent like Leveque's framework, which has been selected to analyze the findings.

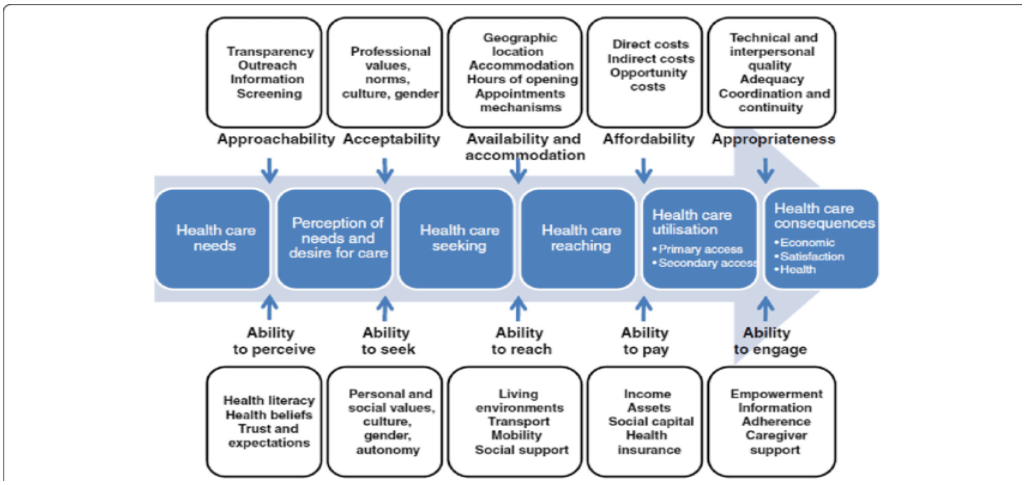
Levesque's conceptual framework of access to healthcare was used to analyze factors affecting access and utilization of SRHR services for PSSD in Nigeria. It was chosen because examine the factors from both demand and supply side (28). Because access is based on health care needs, ability to seek and reach out health care services, as well as provision of appropriate services based on needs. This framework is fitting into any context and can be used in any health problem.

There are six different layers in Lévesque's model and they include: Health needs, Perceptions of needs and desire for care, Health care seeking, Health care reaching, Health care utilization and Health care consequences (Figure 3). Table 2 provides a brief description of the layers.

Table. 2. Descriptions of Levesque's conceptual framework.

Layers	Description
Health needs (professional perspectives)	• Capacity to benefit: intervention that shows evidence of improving health status(morbidity, mortality, QALY, DALY etc)
Health seeking behavior	• Behavioral factors that affect seeking for health care; perceived need, choice, attitude of the provider, risk taking, life style, etc
Perceived needs	• Frequent, urgent, critical, and serious. Need may also be perceived based on age, gender, socioeconomic status, ethnic group.
Utilizations	• Approachability, acceptability and availability.
Health care consequences	• Quality, impact/outcomes, coverage and value for money.

1. **Figure 6: Levesque conceptual framework of access to health care** (28)



Source: Levesque et al. International Journal for Equity in Health 2013, 12:1

3. Chapter Three: Health Policies, Disability Laws and Service Gaps

This chapter presents the review of National Health policies, Disability laws and health service gaps related to access and utilization of SRHR services for PSSD in Nigeria.

3.1. Inclusive SRHR Policies for people with psychosocial disability in Nigeria

Since 1998, the health system of Nigeria is operating based on the national health policy and strategic plans (9). Recently, provision of SRHR services has been among top priority of government as indicated in the background (11). The current national health policy highlighted government's commitment to ensure full access of SRHR services for all citizens (6). These commitments are according to the provisions in the constitution of the federal republic of Nigeria and international guidelines (10). In addition, health policies also acknowledged the roles of cultural norms and religious beliefs and different ethnic communities in Nigeria, but these values are not shared homogenously in all the states and regions in Nigeria (7). This disparity has affected the uniformity and integration of SRHR services in Nigeria. It has also affected the harmonization of SRHR data for decision making at policy level (67). Furthermore, it has make monitoring and evaluations of SRHR interventions in Nigeria difficult due to asymmetry of information (10).

Government of Nigeria through its implementing agencies like the federal ministry of health has been intensifying efforts to provide an enabling environment for improved SRHR services in the country (36). Health policies are formulated to address the current challenges and SRHR needs in the country (9). Most policies focused on the supply and distribution of SRHR commodities like family planning (FP) services, with the aim of ensuring full access of SRHR services in the country especially in the rural areas (10). Recently, some policies have shifted focus to address the demand side by promoting inclusiveness and community participation, the aim is to address equity, gender, stigma and discrimination (5).This action is to ensure access of SRHR services for vulnerable and marginalized groups like adolescents and people with intellectual, sensory, physical and psychosocial disabilities (5). However, because of the diverse cultural and religious beliefs recognized by the policy environment in Nigeria, access to SRHR services still remains a serious challenge for these marginalized groups (9).

Although provision of SRHR services is still not adequate in Nigeria, but considering the situation of PSSD, it is evidenced that they have high demand for SRHR due to inequity in health service delivery (68). Addressing these inequities is mainly through policy and interventional commitment of government (69). But inadequate government allocations and over reliance on donor support cause limitation in capacities of government's machineries to ensure full access to SRHR services based on needs as highlighted in the policy document (6). Another major challenge affecting health policies in Nigeria is poor coordination and overlap of roles and responsibilities among different stakeholders (10). For example, the Ministry of Women's Affairs and Social Development is responsible for managing the affairs of PSSD in the Nigeria (68). But provision of other essential services like health, legal support and education are responsibilities of other ministries (36).This affects the directions of SRHR care for PSSD in Nigeria (9).

In addition, Nigeria is among 21 priority countries of the United Nation Population Activities Fund (UNFPA) for SRHR care of PSSD in sub-Saharan Africa. These countries are selected because of the low SRHR service coverage and high rates of morbidity and mortality from SRHR related causes affecting PSSD (30). In particular, Nigeria has an alarming prevalence of mental illness of about 15% of the population and about 3 million are people living with disability (68). Prevalence of psychosocial disorder ranges from about 20% among adolescent aged group to 33% among adults population (7). Health

policy is needed to specifically address funding and resources mobilization that will promote access of SRHR care for PSSD (7).

3.2. Inclusive Disability Laws and it Influence on SRHR for People with Psychosocial disability in Nigeria

The rights of people with disability including physical, intellectual and psychosocial disabilities have been ratified by the international convention on rights of persons with disability and the protocol options are developed (34). In Nigeria, the national disability bill has not been fully enacted and passed into law (69). In addition, there is no formal system of coordination, implementation and monitoring mechanisms that will ensure full rights for people with disabilities in Nigeria (68). Despite the difference in the phenomenon of right violation among people with disability, the proposed disability act that was sent to national assembly for legislation and incorporation into national laws is specific and unclear about different types of disability and their characteristic challenges in Nigeria (17).

Sexual and gender based violence affecting PSSD in Nigeria is associated with weak legal system and perpetuated of traditional and social norms and values (71). For example, PSSD account for 39% of all sexual abuse and 39.4% of intimate partner violence in Nigeria (35). Women and girls with psychosocial disability in Nigeria are highly susceptible to involuntary sterilization (71).Anecdotal evidence shows that in adolescent girls with psychosocial disability in Nigeria are at higher risk of involuntary sterilization than their female counterparts without disability (70). Although there is no available data that show the incidence of involuntary sterilization for women and girls with psychosocial disability in Nigeria, an empirical research conducted among 224 respondents shows 38.8% (87)of the respondents they heard or knew instances where a woman or adolescent girls with psychosocial disabilities had been sterilized (50). Some of reasons for the involuntary sterilization reported by the respondents are: prevention of pregnancy (36.1%) and financial implication (23.2%) (50). All these have been associated with lack of disability laws that protect the rights or criminalized these practices in Nigeria (50).

PSSD in Nigeria have no freedom to make choice regarding their body or reproductive life because of stigma and discriminations (35). For example, in most rural communities of Nigeria, people are not allowed to marry person with PSSD and a child born to PSSD are kept away from public view, or even killed in some cases because of fear of having a psychosocial disability in family (25). In most African countries, families of both the two intended couple had to ensure that no history of psychosocial disability can be trace in the potential partner's family lineage before any marriage can contracted. Existence of such traits can lead to total annulment of the wedding, these practices have interfere with freedom of choice which is a key component of SRHR and it is also related to lack of legal supports for people with disability (51).

3.3. Identified gaps in SRHR care for people with psychosocial disability in Nigeria

Report of national demographic and health survey (NDHS) is been use to identify and define health needs based on existing gaps and disease burden in Nigeria (4). In 2016, NDHS recommended for improved SRHR services provision, specifically in the areas of family planning, mother and child care, prevention and treatment of STI/HIV (13). These recommendations are based on international agreement and framework for providing SRHR service such as the International conference on population and development (ICPD), the millennium development goals (MDGs), the London FP2020 summit and the sustainable development goals (SDG) (10). Provision of such services has the ability to

reduce maternal mortality by 32%, it will also avert 1.6 million unintended pregnancies and prevent 1 million deaths of children below the age of under five years annually (14).
Despite the above recognized benefits, huge investment and international commitment of government, provision and access to SRHR services remain a big challenge especially for vulnerable and marginalized population like people with a disability (16). In addition, PSSD because of life events and stressors have specifics SRHR needs, they are also faced with number of challenges in the surrounding socio-economic, cultural and physical environment that influence their access the mainstream SRHR services provided for the general population (38). For example, people with psychosocial disability account for 11.8% of out of schools girls in Nigeria (48). These can increase the risk of early marriage, teenage pregnancy and unintended pregnancies as well as STIs/HIV (44).
Information about school enrolment for children and young adults with psychosocial disability is underestimated in Nigeria (52). Report by the British council indicated that more than 90% of children with psychosocial disabilities in Nigeria are not enrol in school system (70). And according to the World Bank, a child with psychosocial disability is 13 times more likely to be out of school than a child without psychosocial disabilities in Nigeria (72). The above findings are similar to those revealed in a study conducted among 270,000 children with psychosocial disability which show only 3.7% (10,000) of them received education to primary school level (48). Another study conducted to explore sexual behaviours and reproductive health knowledge among 103 young people with psychosocial and intellectual disabilities attending schools in Ibadan, southern part of Nigeria shows that 35% of the participants have experienced sex and 25% had a history of rape, about 10 participants had multiple unprotected sexual experiences. However, about 70% of the participants show no knowledge of where to obtain SRHR services (49).In addition, poverty and gender are also identified as major barriers to school enrolment for children with psychosocial disabilities in Nigeria (33).
Incidence of disability from all causes (physical, intellectual, psychosocial and sensory)in Nigeria is 2.32%.In addition, there are about 3.3 million people with disabilities in Nigeria, but 38% of this population is caused by mental and psychosocial causes (35). This figure is also underestimated, because of non-availability of specific health profile of PSSD. Hence, the actual incidence of psychosocial disabilities and their total number in Nigeria are not available (35). The world health organization (WHO) has estimated about 25 million people with disability in Nigeria and 15% are due to mental and psychosocial causes (30). Finding from studies and sample surveys indicated that SRHR care for PSSD in Nigeria is underserved (76). For example, a survey conducted to determine access and utilizations of SRHR services in the public health facilities within Nigeria shows only less than 1% of the total people that accessed those service over 12 months period are PSSD (35).
Studies also predicted high prevalence of HIV among PSSD (19). Although the prevalence of HIV among PSSD is still sparse in Nigeria, but studies from countries with similar context like Nigeria has shown high HIV prevalence among PSSD. In South Africa for example, HIV prevalence among female adolescents with psychosocial disabilities is 12.5% (39). Record from South African national HIV survey of indicated HIV prevalence of 14.1% among people with mental and psychosocial disabilities, the prevalence in general population is 13.1%; this is linked to high rate of sexual abuse among PSSD (78).

3.4. Concluding remarks

In this chapter, main factors identified to affect access and utilization of SRHR service for PSSD in Nigeria are: Health policies are been formulated to acknowledge the roles of

religion and cultures of different ethnic communities in the country, these have been found to affect access of SRHR services in PSSD because of the influence of perceptions in the community, societal norms, family values and individual attitudes. Other factors related to the policy are poor coordination among different stakeholders that are involved disability care and over reliance of external funds for SRHR services in the country.

Lack of disability laws in Nigeria has also found to influence sexual violence like involuntary sterilization, affect freedom of choice and pleasurable sex including coercion and gender-power imbalance. In addition, underestimation of prevalence and lack of information about SRHR needs of PSSD as well as none reporting of cases of sexual abuse like rape and other form of gender based violence are among the major gaps affecting provision of SRHR services for people with PSSD in Nigeria.

4. Chapter Four: Enablers and Barriers for access and utilization of SRHR service among people with psychosocial disability in Nigeria

In this chapter, Leveque's model is applied to analyzed factors influencing access and utilization of SRHR services for PSSD. Taking into consideration that factors are inter-linked (28).

4.1. Demand side factors:

Factors described in this section include; abilities to perceive, seek, reach, pay and engage with SRHR service.

4.1.1. Ability to perceive (health literacy, information, belief trust and expectations)

Many scholars have reported the influence of health literacy, attitudes, beliefs and perceptions as a major factor for health seeking behaviour (17). For PSSD, these factors are embedded into hostile religion doctrine, the conservative norms and values (51). In Nigeria, studies have shown that these factors are influenced by sustained prominent roles of traditional healers in rural communities (16). Studies in Nigeria also found that seeking SRHR care for PSSD is dependent on behaviour, level of health literacy and understanding of the community about the causes and perceived SRHR needs of PSSD (38). A study conducted among 250 family members of PSSD in Kano state Northern Nigeria show that 34.0% prefer spiritual (exorcism) healing for their client with psychosocial disability, 18.0% prefer the use of traditional herbal medication and 2% believe that psychosocial disability occur as a result of the sins committed and hence should not receive any form of treatment (57).Another study found that most family members of PSSD beliefs that their lives is about charity and alms-begging and not expecting them to engage into sexual relations or desire to have families because they cannot afford the financial demand involved; this practice has enjoyed the support of cultural and traditional beliefs (38). In most part of northern Nigeria, alms-begging using PSSD have been reported to invoke certain empathic response of the public to assist by giving them financial support. This financial benefit has affected the expectation of both PSSD and their family members to access health service including SRHR care (21).

4.1.2. Ability to seek care (socio-cultural values, personal values, gender and autonomy)

Socio-cultural factors like stigma and discrimination can constitute significant barriers for access to healthcare services (15). It also has big influence on the actions of individuals, families and the communities to accept or reject certain healthcare service provided for general population (16). For PSSD in Nigeria, who are often seen as asexual beings or worthless and lack of support from families and friends particularly on sensitive issues like the SRHR, this can have serious implications on their access to SRHR service (57). In most African countries, family members have been found to prevent PSSD from public places including access to health facilities due to stigma (51, 58).

The situation is similar in Nigeria because studies have shown that socio-cultural norms and values of society towards PSSD have negative influence on their health and wellbeing (21).Incidences have been reported were PSSD are been seen as unclean or people that have committed abomination (25). In some severe cases they labelled as witchcraft and subsequently kill them in public (47). A case report from Benin City, Edo state in the southern part of Nigeria revealed that woman with PSSD was burnt to death in public, because people beliefs she was responsible for the misfortune in the community (38).The report concludes that fear of unjustified killing can affect public

interactions of PSSD with the community including ability to seek for healthcare (38). Another study from Ghana found that PSSD attending antenatal clinic are not allowed to ask questions because health workers assumed that they are ignorant of their health conditions (66).

In comparison to men with psychosocial disability, studies have reported gender also has influence on access of SRHR service for women with psychosocial disability (88). Report of the ministry of women affairs and social development in Nigeria indicated high risk of involuntary sterilization, decreasing chance of getting married and high rate of divorce among women and girls with disabilities including those with psychosocial disability. In addition, girls with psychosocial disability are likely to be dropped out of school than boys' counterpart (33). Women with psychosocial disability are also more likely to be unemployed, earned less money and suffer more stigma than their men counterpart (32). These factors has been found to affect knowledge and views of women with psychosocial disability and the community on their access to SRHR services like antenatal care and other sexual and reproductive health services (32,33).

People with psychosocial disability have also been found to be over reliant on the support friends and families to facilitate their daily lives, which have affect their autonomy and limit freedom to opportunities including freedom of choice, sexual desire and access to health care service like SRHR services (43, 44). The study from South Africa also reported effect of internalizing low self-esteem by PSSD about themselves and their conditions which also affect their autonomy to express themselves or interact fully in public places like health facilities (32).

4.1.3. Ability to reach (transportation, mobility, support and living environment)

Studies have shown that travelling for long distance to health facility is cumbersome and costly; lack of money to pay for transportation has always affect access to healthcare services (16). For PSSD who could not afford the cost of transporting themselves, but require financial support from family members' which can lead to financial burden on their families and ultimately affect their access to health services (77). Findings of a qualitative study conducted from Niger delta region in southern part of Nigeria show that high cost of transportation can affect access of PSSD to health clinic for treatment or follow up. The study also reported worsening and relapse of genital infection among PSSD due to delay in mobilizing resources to transport a client with psychosocial disability (81).

It involved the family support, use of peer groups and other social networks to promote access of healthcare services through awareness, especially among vulnerable and marginalized people in the society (17). Because PSSD are likely to have few friends, their social support is limited and network can be either supportive or harmful (31). Finding of a case control study among 30 young people with and without psychosocial disability and assess their impact of social networks on access of SRHR service, shows adolescents with psychosocial disability believes more to misconceptions about sex than the other group. For example, some adolescent with psychosocial disabilities believes that they cannot have sex or become pregnant (45).Another study found that lack of social support reduces awareness and increase the risk of early sexual exposure for teenage girls with psychosocial disability than their peers with no disability (19). Some studies relate increased risks of unprotected sexual practices among PSSD people with lack of social network (61).

Some authors also report that social support from friends and family members is based on beliefs; knowledge and relationship with the PSSD. For example, family member who believe that PSSD are asexual beings, are not likely to support or facilitate such needs

(22, 38). A study in Ghana reported bad condition of roads and flooding during raining season as a major difficulty affecting pregnant women with psychosocial disability to find assistant who is willing to them to the hospital (65).

4.1.4. Ability to pay (social health insurance, income and assets)

Currently, only about 2% of the total population is enrolled in the national health insurance scheme (NHIS) (67). Majority of the people enrolled in NHIS are employee in the formal sector (4). For clients not enrolled in the NHIS, all cost of health services received including; consultations, investigations, prescription, admission and follow-up have to be paid out of pocket (67). Study has shown that 76% of health services in Nigeria are paid by out-of-pocket payment (69). For PSSD in Nigeria, their low educational status, unemployment and poor income have been found to affect their ability to pay for health care services (74). Another major barrier affecting the ability of PSSD to pay for health services is high rate of poverty (32). In Nigeria, Nine out of 10 persons with disability including physical, sensory, intellectual and psychosocial are living below the poverty line (17). Findings of a study conducted among 1,093 PSSD shows that 84% are living on below $1 a day (47). A study also described the link between, school enrolments, employment, poverty and ability to pay for health care service among PSSD in Nigeria (21). In 2016, reports of the ministry of women affairs and social development in Nigeria, relate poverty with the lack of basic needs like food, shelter and healthcare as a major problem affecting PSSD in the country (35).

4.1.5. Ability to engage (information, empowerment and adherence)

Available Studies have shown that people with psychosocial disability in Nigeria are often unaware that they can access healthcare services in the mainstream health centres (57). Some studies indicate that PSSD lack basic knowledge and understanding of SRHR problems and possible solutions (22). For example, a study conducted in Ibadan, Oyo state in southern part of Nigeria show that majority of people with psychosocial and intellectual disability are unable to recognize any of the family planning methods like contraceptive pills and implant (49). These findings are similar to those reported by a study conducted among people with psychosocial and intellectual disability in Ghana, where majority are unfamiliar with the basic information of pregnancy and STIs (51). The two studies conclude that lack of SRHR knowledge among PSSD is affecting their access to those services (49, 51). A report from Nigeria indicated government commitment to empower people with disabilities in the country; emphasis was given to economic empowerment through microfinance bank and access to vital information including health awareness. However, more attention was given to people with physical disability, sensory disability like blind and deaf as well as albinos. The report also indicated that people intellectual and psychosocial disability received little attention because there is no strong association or umbrella that is advocating for their empowerment at national level (109). Information about adherence to access of SRHR care for PSSD has been very limited. However, it has been shown in the background that PSSD more often rely on family and friends for information, motility and cost of health care and that can affect their adherence access and comply with SRHR care (47).

4.1.6. Concluding remarks

In this section, main factors that are found to influence access of PSSD to SRHR services in Nigeria include: lack of knowledge about SRHR needs for PSSD, attitude and beliefs in the community which are linked to the ability to perceive. Lack of support has been found to affect abilities to seek, engage and reach SRHR services. In addition stigma and discrimination also affect the ability to seek. Costs of transportation also affect the ability

to reach. Lack of social insurance service and high poverty rate among PSSD affect the ability to pay. These factors are however inter-linked together.

4.2. Supply site factors:

Factors described in this section include; acceptability, approachability, appropriateness, availability, and affordability of SRHR service for PSSD in Nigeria.

4.2.1. Acceptability (professional values, norms, culture and gender)

Attitudes of healthcare staff and service providers are can be affected by professional values, cultural norms and gender (58). Studies have been very consistent in reporting lack of acceptance of PSSD as a major barrier for access to health care (37). In Nigeria, acceptability of PSSD has been found to affect access SRHR service. Healthcare staffs have been reported to be insensitive either on purpose or due to lack of knowledge about the SRHR needs of PSSD (19). Study has reported physical, verbal, emotional and sexual abuses by healthcare staff on PSSD which affect their access to SRHR services (38). Some healthcare staffs have been reported to be avoiding any physical examination that requires using their hands on PSSD (60). Healthcare staffs are also found to be requesting test that are not very necessary, for example HIV testing in client with no risks (63).Others are reported to physical restraint pregnant women with psychosocial disability during labour (61). In addition, healthcare staffs are also found to enforced sterilization on women psychosocial with disability or use of abusive terms to describe pregnant women with psychosocial disability (64). These actions by healthcare staffs have been found to greatly undermine the morale and desire of PSSD to access SRHR services (66).

In a community based study conducted among 57 healthcare staffs of a faith based hospital in Enugu, south-eastern part of Nigeria about their experience on prevention of mother to child transmission of HIV in people with mental and psychosocial disability, about 69% of the respondents felt that people with mental and psychosocial disabilities are a nuisance and 5% reported that provision of HIV services for people with mental and psychosocial disability is waste of money (46) These findings are similar to those reported by a studies conducted in countries within sub-Saharan Africa. For example, In south Africa it was found that women with psychosocial disability have no place in the realm of SRHR services especially childbearing, because some healthcare professionals often assume that PSSD are sick and should only seek for healthcare on issues related to their conditions (37). And in Zimbabwe, a study conducted among17 women with psychosocial disabilities show that 12 of these women expressed anger regarding how they are treated by healthcare staffs in the family planning clinic (41).

4.2.2. Approachability (transparency, outreach, information and screening)

Some authors have linked lack of information about the health challenges of PSSD among the healthcare staffs as major factor affecting cause access to health care (58). Healthcare staffs are also reported to avoid patients with psychosocial disability who could not explain their health problem by giving priority to other patients without disability, with the aim of serving time. This has been found to affect the outreach of SRHR service to PSSD (39).

Another study have indicated healthcare staffs are preferred to give information regarding SRHR problem of PSSD to their family members or caretakers than disclosing the information directly to them, which has created negative impression that PSSD cannot approach SRHR service alone (74).In addition, lack of privacy and confidentiality in health issues of PSSD can lead to mistrust and affect transparency in the provision of SRHR services(43).Findings of a qualitative study among men with mild intellectual and

psychosocial disabilities in Nigeria, found that having good knowledge on family planning and contraception does not always translate into safe sex practices (44). For example, some young men with psychosocial disability are found to be engaging in risky sexual practices despite having good sexual knowledge due to difficulties of securing condoms. Some of the reasons highlighted are lack of trust and confidentiality at the youth friendly canters (44).

4.2.3. Appropriateness (technical, interpersonal, quality, adequacy, coordination and continuity)

Studies have indicated that provision of appropriate SRHR services according to the need of PSSD. In Nigeria for example, studies have found that access to social protection services like the police and legal support for victims of sexual and gender based violence is always difficult, especially for PSSD because such services are only provided for general use not specific to need of marginalized group in the society (38). Study in Uganda reported that staffs in the sexual and reproductive health clinic are not well trained to effectively communicate with people with intellectual and psychosocial disability, and staffs of the mental and psychiatric hospital have little or no training in sexual and reproductive care (60). In addition, a study from South Africa indicates that sexual and reproductive health clinics are poorly prepared to deal with people with developmental, intellectual and mental disability. For example, required drugs and equipments for SRHR service are always available in the psychiatric hospitals (63). A study from Ghana, reported that pregnant women with psychosocial disability often received wrong treatment in the reproductive health clinic, for example paracetamol have been frequently prescribe to them, even for a serious health condition because the midwife cannot understand their complains (65). Similarly, healthcare staffs in Senegal are reported to make diagnosis based on personal assumption and prescribe wrong treatment because client with psychosocial disability are unable to give good medical history (43).

4.2.4. Availability (geographical location, hours of services, accommodation, and mechanism of appointment)

Factors like buildings, elevators, personnel, electricity and water supply are general barriers that can affect the availability of health care services (16). However, for PSSD people, factors affecting their access to available SRHR services in the mainstream health care are beyond those listed because those services are often not freely available to them (77). In Nigeria, studies have shown that there is lack of delivery wards, trained midwives and poor referral system in most psychiatric hospitals are the major problems affecting access of SRHR service in PSSD people (74, 81). Similar findings are reported in Ghana, where pregnant women with psychosocial disability are experiencing serious or life-threatening complications due to non availability of a trained midwife and poor medical equipments and poor referral systems in the psychiatric hospitals (61). In Uganda, a study also highlighted lack of adjustable delivery beds, trained personnel and emergency obstetric drugs in the mental home as major barriers to SRHR services (58).
Transportation and mobility are other barriers that hinder access of PSSD to SRHR services. For example studies from 3 countries within sub-Saharan Africa (Uganda, Zimbabwe and Ghana) shows difficulties faced by women with psychosocial disability while accessing SRHR care. In Uganda, it was found that pregnant women with psychosocial disability are been rejected by taxi drivers and in other public transports on their way to attend antenatal care (39). In Zimbabwe, women with psychosocial disability usually require an assistant to support them in the hospital, but because of the challenges in transportation, most people are not willing to support them. In addition there is an extra cost of transportation that as mentioned earlier (41).

4.2.5. Affordability (direct, indirect and opportunity cost)

Affordability of health services is generally associated with serious financial hardship due to high out of pocket payment which ultimately affect the ability to access and utilize health services (67). The situation for PSSD in Nigeria is even more challenging because findings of a study conducted in Port Harcourt in the southern part of Nigeria shows that when the families of PSSD are unable to pay for their hospital bill due to financial difficulties, their access to the basic health needs and overall well-being will be affected (74). Another study also found that most caregivers suggest that health care for PSSD should be made free in order enhance their access to basic health needs (81). Some caregivers revealed that meeting up with health care expenses for PSSD is difficult; hence they will prefer to seek traditional care for their client (78).

As highlighted already, PSSD are likely to be unemployed and earn less money than those without disability (32).They also depend on the income of employed members of their family for healthcare (58). It was reported that over reliance on family and friend is associated with high inconvenience due to indirect cost of transportation and time lost (47). Study has shown that relatives who accompany PSSD to health facility for appointments, have to be absent from their work or business places which can lead to loss of income. Some of the relative show concern regarding the time they had to spend in the hospital on account of health needs of PSSD (77).

4.2.6. Concluding remarks

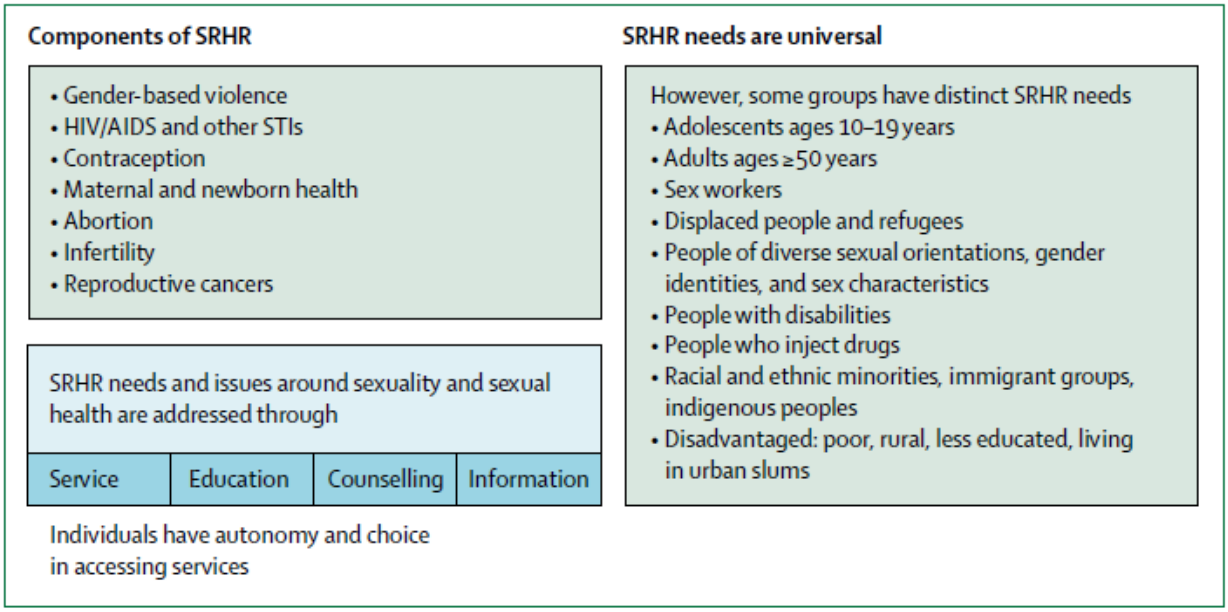
In this section, main factors that are found to influence access of PSSD to SRHR services in Nigeria include: Attitudes, lack of awareness and poor knowledge about SRHR needs for PSSD are found to be a major barriers of acceptability and approachability of SRHR service. In addition, SRHR service in Nigeria are also found to be none disability friendly especially legal support. Challenges related to communication between the client with psychosocial disability and healthcare staffs are found to affect appropriateness of SRHR service, which in some cases can lead to misdiagnosis and wrong treatment. Healthcare staffs in the psychiatric hospitals in Nigeria are not often trained to provide SRHR care and basic equipment require to deliver SRHR service are not often available in the psychiatric hospitals. Lack of social insurance service and high out of pocket payment for health care in Nigeria was also found to affect the affordability of SRHR service in PSSD. These factors are however inter-linked together.

4.3. Intervention for promoting access and utilization of SRHR service for people with psychosocial disability in Nigeria

This chapter presents the available SRHR interventions for people with psychosocial disability in Nigeria and evidence based interventions from other countries.

As described in the background, countries around the world have affirmed their commitment and intensify efforts to promote access of SRHR service for people with disability during international conventions on people disabilities (85, 89). Improved provision of SRHR service was among top priority and key areas reiterated include access and utilization basic SRHR services throughout the life cycle base on the population need (90).

Table.3. Component of SRHR according to population needs (1)



Source: www.thelancet.com vol. 391, 2018

Table.4. SRHR services that should be accessible to all person who need them regardless of age, gender, marital and socio-economic status, race, ethnicity, disability and orientation (1)

Panel 8: Essential package of sexual and reproductive health interventions

- Comprehensive sexuality education
- Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence
- Prevention, detection, and management of reproductive cancers, especially cervical cancer
- Information, counselling, and services for subfertility and infertility
- Information, counselling, and services for sexual health and wellbeing

Source: www.thelancet.com vol. 391, 2018

The convention also gives emphasis on integrating care of people with disability in the design, implementation, monitoring and evaluation of all SRHR programs. Other strategies employed are; strengthening health services that address key SRHR issues affecting people with disability like gender inequality and promote the meaningful engagement with civil society organizations (87).

Following this convention, countries around the world have been making different attempt to promote access and utilization of SRHR services for people with psychosocial disability (89). In Nigeria, government appointed a senior special assistant on Disability Matters, whose responsibility is to assist the presidents in promoting health and rights of people with disability (68). The senior special assistant is also responsible for design and implementation of all interventions for people with disability in Nigeria (68). However,

evidence shows inconsistency between available interventions and the specific SRHR needs of people with psychosocial disability (35). Reports also show no any major difference observed between SRHR services for general population and that people with disability in Nigeria (87).

In most developed countries, provision of SRHR services are integrated into mental and psychosocial services (96, 97). Currently, there is no standard intervention or uniform program regarding SRHR care for people with psychosocial disability; different countries have adopted different strategies to address SRHR needs of people with psychosocial disability (89). In the United States, mix- method approach has been adopted to enhance access of SRHR care for people with disability generally including those with psychosocial disability. Time has been set aside in public health clinics open only to the people with disability. In addition, civil society organizations are empowered to support SRHR care for people with psychosocial disability in the communities' health services (98). Some authors have however argued that mix-method approach can create confusion about services availability which can affect the effectiveness of interventions (99).

Integration of SRHR awareness through education sector is another area of intervention that is been encouraged, this is done through advocating for school enrolment for children with disability (68). Comprehensive sexuality education has always been considered as a key intervention of economic empowerment and increase awareness of SRHR issues (48). However, studies have found that school enrolment of children with disability in Nigeria is significantly low (49). Report by the ministry of women affairs and social development in 2013 show a national primary school net attendance ratio (NAR) of 6% for boys and girls with psychosocial disability in Nigeria (68). Among the major reasons of low school enrolment in young people with disability in Nigeria that are highlighted in the report include; cultural beliefs and perceptions of the people toward disability. For example people in the southern part of Nigeria have been found to regard individuals with disability as unproductive, majority are reluctant to give them moral and financial support they need for their education. Culture of arms begging using people with psychosocial disability and the financial benefit associated with it has been found to be major factor affecting school enrolment in the Northern Nigeria (68). Evidences have shown that comprehensive sexuality education can remarkably improve access of SRHR service among people with mental, psychosocial and intellectual disabilities in countries where such services are made available (90). For instance, the United Kingdom, the United States and other countries in the western European have recorded huge progress in area of sexuality and disability. This progress has been attributed to the effective method of communication regarding SRHR problems and solution through comprehensive sexuality education (90). In the United Kingdom, the government introduced national initiatives that effectively create awareness about pregnancy and STD among adolescent with disability including those with psychosocial disability (100).

In addition, SRHR interventions for people with disability are now focusing on issues of stigma reduction, behavioural change and economic empowerment. Others are social justice & inclusiveness, abortion, nutrition and housing (89). This movement has been very slow in Nigeria, influence of socio-cultural barriers and political environments have affected government's commitment to reform SRHR laws like the abortion law in the country (68). In Sweden, canters have been established where people with intellectual and mental disabilities can receive counselling, medical examination, treatment and therapy about sex and sexual relationships (103). These canters provide multi-professional services from medical and psychosocial experts; they are also situated in strategic locations. Staffs of these canters are trained to express positive attitudes and

to respect confidentiality of their clients. This approach has been found to play an important role in promoting access of SRHR care among young people with disabilities (102).

Review of various literatures shows the benefit of counselling and psychosocial supports on victims of sexual and gender based violence. In Nigeria, government has earmarked funds to establish counselling and psychosocial support canters in the communities (69). These canters are meant to provide support services, self protections and life skill techniques for victims of sexual and gender based violence. However, the attempt has failed due to none availability of data that will allow for policy decisions and it is because people are not reporting cases of sexual abuse (16). In Australia, Government established a commission against violence on people with psychosocial that is responsible for cases abuse and neglect within institutional and residential environment. The main function of this commission is to protect, investigate and enforce laws on violence against people with disabilities (104). Council of Australian Governments (COAG) in collaboration with Law, Crime and Community Safety Council (LCCSC) enacted a uniform national policy that is legally enforcing prohibition of sterilization in people with psychosocial disability without their full consent (105).

In addition, Government also prioritized funding to improve provision and access of appropriate SRHR commodities need by people with psychosocial disability that are victims of sexual violence (104). Government also provides long-term support, including resources for capacity building and violence prevention (104). Furthermore, Australia government updated the national action plan on prevention of violence against all women with disability (physical, psychosocial and intellectual) (2010-2022) to a more inclusive and non-discriminatory approach (106). Information and communication materials on violence against women and girls with disability were developed and disseminated (104). People with disability themselves, frontline workers, their families, advocates and relevant professional are involved in decision-making process for policies and program (106).

Countries in Africa have also been making effort to implementation SRHR intervention for people with psychosocial disability. Most countries have adopted the United Kingdom model of comprehensive prevention strategies. Some of the countries have reported success in the area of increased availability of SRHR services, improve knowledge and attitude of the providers and support from the community (95).

Figure.7. United Kingdom model for disability inclusion (110)

Source: Retrieved from http://www.who.int/en/news-room/factsheets/detail/disability-and-health.

5. Chapter Five: Discussion

This chapter presents the discussion of the study findings as seen in chapter 3, 4 and 5. The findings are interpreted and the linkages between the enablers and barriers were also explained. Evidence-were drowned from Nigeria and other contexts (both similar and developed countries).

5.1. Discussion

5.1.1. Demography, laws and gaps of SRHR services for people with psychosocial disability in Nigeria.

Despite numerous evidences about SRHR challenges of PSSD, the actual scope and magnitude of problem is not readily available in Nigeria. Evidences from different literatures are also not consistent on the pattern and root causes of the problems. For example while some studies reported similar findings, other studies are found to contradict each other regarding the causes of SRHR problem, barriers and enablers for access and utilization of SRHR services. This is not surprising in a country like Nigeria due to its diversity and different ethnic group.

The evidences have shown that demographic variables like age, gender, ethnicity and religion to influence on access of SRHR services for PSSD in the Nigeria. Study also indicated that priority for SRHR care in Nigeria is given to women of reproductive age group (15-49). However, women and girls with psychosocial disability who are most common victims of sexual and gender based violence, discrimination, relationship issues and sexual right violation have been frequently omitted from national SRHR policies and interventions. For example, in this review we have seen that there are high risks of involuntary sterilization among women and young girls with psychosocial disability. Which is both reproductive right violation and gender based violence because the risk was much lower among men and boys with psychosocial disability. The review also shows lack of commitment from the government to established disability laws in Nigeria, this was evidence by the delay for nearly 2 decades following ICPD and CEDAW conventions, yet the government in Nigeria couldn't pass disability bill into law. Passing disability bill law in a multi-cultural nation like Nigeria can protect the right of PSSD including sexual and reproductive right and ensure freedom of choice.

In additionally, the review indicated the effect of acknowledging the roles of different cultural and religion belief in national health policies, this have been found to affect provisions of SRHR services differently, between the north and the south region of Nigeria. It was also found to affect coordination of stakeholders at national level because of the difference among interest group. Another major issue highlighted in this review that is affecting access and utilization of SRHR service for PSSD is the problem with data. For example, in the World Bank report it was indicated that population of PSSD is

grossly under-estimated in Nigeria. This review also found that incidence of psychosocial disability is not available. Some of the factors responsible for non availability of this information highlighted in the review include; not reporting cases of sexual abuse and other reproductive rights violation that are related to SRHR care of PSSD. The above factors have been contributing to making SRHR service inequitable and inaccessible for PSSD in Nigeria.

5.1.2. Barriers and Enablers of access to SRHR services for people with psychosocial disability in Nigeria.

As indicated in this study, the barriers and enablers for SRHR care of PSSD are multi-factorial, but major ones identified include; lack of awareness about SRHR needs for PSSD among services providers including policy makers and healthcare staffs. This can be related with lack of data about the burden and needs for SRHR care by PSSD in Nigeria. Lack of awareness can also affect policy decisions, provision and distribution of SRHR services within the country. It will also affect equity and accesses of SRHR care as well the skill, training and attitudes of health care staffs. In most psychiatry hospitals in Nigeria, Health care staffs have found to have little or no SRHR training; this has also contributed to limited access of SRHR care for PSSD. This challenge can be avoided through integration of care and good referral system as shown by some interventions in the developed countries.

Another major barrier affecting access of SRHR services is cost of care, which have been linked with lack of social insurance services for PSSD, indirect cost like transportation and lack support from the family and friends. This is not surprising for a country like Nigeria because only 2% of the total populations are enrolled in the insurance scheme (NHIS) most of them employee in the formal sector. In addition, the review also shows relationship between low school enrolment for children and young PSSD, unemployment, poverty and access to healthcare. These factors have been reported to directly or indirectly affect affordability of SRHR which ultimately result in limited access to SRHR care for PSSD in Nigeria. In addition, low school enrolment has also found to contribute to poor level awareness about SRHR issues and services among PSSD. Number of evidence has shown the benefit of comprehensive sexuality education, especially on awareness about pregnancy, STIs and health services available. But due to the low school enrolments, majority of PSSD in Nigeria have been found to be not aware of their right to sexual pleasure, reproduction and choice. They are also found to believe in the wrong perception of the community that they are asexual; they don't have desire for children or they know nothing about their health condition.

A number of articles have reported stigma and discrimination as a major factor affecting access of SRHR care for PSSD in Nigeria. This review have demonstrated the effect of stigma and discrimination on both acceptability and approachability of health services, it

also has a linked with low level of awareness in the community and lack of strong legal support like disability law that will prohibit or criminalized any form of discrimination against PSSD. Furthermore, different culture and religion in a country like Nigeria can affect general health needs. Hence, behavioural changes program is need to promote good attitude, change perceptions and understand specific SRHR needs of PSSD in the country. Negative attitude of healthcare staffs with the combined effects of stigma and discrimination have been shown to have serious effect access to SRHR services for psychosocial disability in Nigeria. A behavioural change interventions therefore, need involved both the communities and health facilities level in order to promote access of those services to PSSD.

Some of factors in this review have been reported from other countries within sub-Saharan-Africa. For examples are; PSSD are often denied access because of the strong belief that they are asexual and should only require psychosocial care, this perception have been found in four different African countries which means that this thought is not only within Nigeria but intentional; hence the need for a combined international commitment to create more awareness and change this wrong perception. Another important factor is information and communication barrier; although it is general problem for all people with disability, but it effect was more pronounced among people with psychosocial and intellectual disability than those with physical disability. Social support from family and friends is another factor that was found to affect access of SRHR services people with psychosocial disability in most African countries. This is because of roles of social support in information sharing, transportation and financial support. However this kind of support often comes with inconvenience and additional cost like the cost on the family members that go with the individual having psychosocial disability to the health facility, there is also loss of productivity time, for a family member that is working or doing business. All these multi dimensional factors inter-relate to affect access of SRHR care of PSSD in Nigeria; thus an empowerment services are need to equip PSSD with life skill and economic free so that they can access health care service more easily. Other studies relate information and communication barrier with lack of privacy and confidentiality issues which can be a violation of fundamental human rights and also found to affect autonomy. Additionally, physical availability of health facility is another general problem that was found to a big challenge for PSSD. However, most studies did not provide enough information that is specific and detail enough to explore their effect on access to SRHR care for PSSD.

This review also found that most studies focus on availability and affordability of SRHR care for PSSD, less focus was given to the other component of the supply site factors. Information about the demand site factors are mainly related to ability to reach and to

pay for the SRHR services as we have seen in over reliance of PSSD on family member to access or pay for health services. However this review shows the effect of factors like gender, attitudes, cultural norms, sigma and discrimination on abilities to perceive, seek and engage as indicated in the framework.

5.1.3. Interventional approaches to promote access and utilization of SRHR care for people with psychosocial disability in Nigeria.

As shown in this review that currently there is no standard interventional approach for improving access and utilization of SRHR service available. Countries have adopted different methods in order to improve access of those services and address inequalities. One approach that have been very persistent in most counties is integration of SRHR service into the mental and psychosocial services, this approach has been found to be very effective especially in developed countries in Europe, UK, US and Canada. Another area for interventional approaches is by improving skills, attitudes and knowledge on the healthcare staffs especially on basic SRHR services like contraception, emergency contraception and delivery. As already described in this review, these were among the major services needed by PSSD in Nigeria.

Rights of PSSD to health care including SRHR are another important intervention that has been found to promote access to SRHR care. In this review, it was reported that there is an ongoing effort by the Nigerian government to pass disability bill into law and the benefit of doing so has also been described. Some benefits of disability law can be derived from other countries, Australian example show how government law enforcement agency can collaborate with the community to ensure sexual and reproductive rights of people with disability. Finally, multispectral approach has been found to be most effective because it gives the opportunity for involving different stakeholders of SRHR care and PSSD.

5.2. Study limitations

1- Some of the documents used in the review like government policies, reports and laws are about people with disability in general and not specific to PSSD.
2- Little information is available for PSS in Nigeria and references were also obtained from countries with similar context. However, within Nigeria itself there are over 350 ethnic groups; hence no context within sub-Saharan African countries can address all socio-cultural difference across all Nigeria's society.
3- Interventional approaches for improving access that are used in this review are mainly from high income countries and the context is different from that of Nigeria.

6. Chapter 6: Conclusion and Recommendations

6.1. Conclusion

Nigeria is multicultural with large population and inadequate provision of health services especially the SRHR services. Although government is committed and investing highly into provision of essential SRHR services especially family planning service in country. Access and utilization of PSSD in the mainstream SRHR care is limited due to number of socio-cultural, economic and institutional barriers. Provision of SRHR Services in Nigeria is mainly focusing on addressing the unmet needs of family planning due rapid population growth. However, the needs for SRHR care among PSSD requires all components like the services for gender based violence, prevention and treatment of STIs/HIV, fertility and reproductive services. In addition, PSSD also require comprehensive sex education, right to sexual and reproductive choices including freedom to choice and access without coercion as well as referral service. Ensuring access to these services therefore need multi-sectoral where enablers and barriers of demand and supply sides from within and outside health system will be identified discussed and addressed by the stakeholders.

Findings in the different literatures and from various contexts used in this review shows influence of policy, laws, socio-economic, cultural and beliefs on access and utilization of SRHR service for PSSD in Nigeria. They are strong enough to make general conclusions regarding the barriers and enablers influencing access of those services among PSSD in Nigeria. However, evidence was also derived from countries other than Nigeria, and in order to have deeper understanding of these factors (barriers and enablers) and how they relate to context in Nigeria.

6.2. Recommendations

Going by the findings in the reviews, the following recommendations has been made to improved access and utilization of SRHR services for PSSD in Nigeria:

6.2.1. At policy level

1. National assembly should collaborate with the ministry of justice to ensure speedy passage of disability bill into law. Disability law should be made to criminalize sexual and gender based violence against all PSSD, specifically it should prohibit harm practice like involuntary sterilization of women and girls with psychosocial disability. The laws should also ensure sexual and reproductive right of PSSD by promote the freedom of choice, rights to sexual relationships and have children without any form of stigma, discrimination or coercion. Doing this can promote access and utilization of SRHR service because both service providers and the community can be held accountable on their actions and attitudes towards PSSD.
2. Federal Ministry of health, Women affairs and Education should coordinate and improve on existing SRHR policies in Nigeria. They should make sure that comprehensive sexuality education is implemented in all special school for people with disability in Nigeria. They can also collaborate to identify policy gaps at the

formulation or implementation level. For example, this review shows the effect of acknowledging role of culture and religion on access of SRHR care for PSSD in Nigeria. And how it has affected the provision of SRHR services in Nigeria, but through coordination this policy gap can be corrected at formulation level. Other potential policy gaps that can be address include; poor funding and over reliant of external donors as well as lack of SRHR data about PSSD that should be use to make informed decisions. All these gaps can be address through effective policy formulation which can derive an independent and sustainable funding mechanism, promote community participation to reduce the effect of culture and religion as well as training and supervising health care staff to implement these policies

6.2.2. At Service delivery level

There is need for government agencies and relevant stakeholders (NGO, CSO, and FBO) in SRHR care for PSSD to:

1- Ministry of health should Strengthen SRHR service delivery by conducting regular training for healthcare staffs in order to build their knowledge, skills, attitude and capacities on communication technique, treatment protocols and code of ethics that will ensure health workers have good understanding of SRHR challenge of PSSD and also handle their issues with utmost respect and confidentiality.

2- Civil society organization and relevant NGOs should advocate to government on scaling up SRHR services in Nigeria so that more people can access the services without difficulties.

3- Ministries of education and labour should improve livelihoods and opportunities for PSSD by enhancing school enrolment for young PSSD while Ministries of employment and labour can provide rehabilitation centres integrated with skills acquisition in all states of Nigeria. So that PSSD that have been treated and recovered can be self-reliant. Doing this will reduce unemployment and increase their income generation among PSSD. Thus empowering them to make decisions for themselves and be able to afford healthcare services.

4- Health care staffs at the psychiatric hospitals can be trained to offer basic SRHR services like family planning services, staffs should also be equipped with soft skill of identifying danger signs during pregnancy and delivery so that the client can be refer to most appropriate centres. A good referral system can be establish between the different service providers so that people with disability that are in urgent need can be refer immediately.

6.2.3. At the Community Level:

1- Ministry of women affairs and social development in collaboration with ministry of information, education and civil society organizations should educate the communities about sexual and gender based violence against people psychosocial disability issues. This can be done through mass media campaigns or by the use of disability champions like a popular celebrity or a renowned person with disability in Nigeria, through this approach effect of stigma and discrimination toward psychosocial disability can be reduce.

6.2.4. At the level research:

1- There is need for National demographic and health survey (NDHS) and National bureau for statistics to established (NBS) to improve on data collection about PSSD and their health needs.

2- Federal ministry of health and universities in Nigeria need to invest more on health research.

3- Health researchers need to investigate the scope, pattern and magnitude of SRHR problems of PSSD in Nigeria.

Reference:

1- Starrs A. A Lancet Commission on sexual and reproductive health and rights: going beyond the Sustainable Development Goals. Lancet. 2015;386 (9999):1111–2.
2- Chandra PS, Chand P. Towards a new era for mental health. Lancet [Internet]. 2018;392(10157):1495–7. Available from: http://dx.doi.org/10.1016/S0140-6736(18)32272-
3- National Mental Health Consumer & Care Forum. Unraveling Psychosocial Disability in Nigeria. 2011.
4- NDHS. Nigeria Demographic Health Survey.2016.NDHS.ww.ndsh.gov.ng
5- FMOH. Guidelines for participation of people with disabilities in research and access to sexual and reproductive health services in Nigeria. 2016. www.fmoh.gov.ng
6- FMOH. National Health Service delivery. Federal Ministry of Health, Nigeria. 2014. www.fmoh.gov.ng
7- FMOH, Abuja .National policy for mental health service delivery. Federal Ministry of Health.2014. www.fmoh.gov.ng
8- World Health Organization (WHO). Key Issues in the Implementation of Sexual and Reproductive Health Program. 2017. https://www.who.int/reproductivehealth/topics/linkages/en/ Geneva.
9- FMOH, Federal Ministry of Health. Abuja. National reproductive health strategy. 2005–2017; 2006. www.fmoh.gov.ng
10- FMOH, Federal Ministry in Nigeria. Nigeria Family Planning Blueprint (Scale-Up Plan) October 2014. 2014. https://www.healthpolicyproject.com/ns/docs/CIP_Nigeria.pdf.
11- NPC. National Population Commission of Nigeria: Implications and Challenges of over population in Nigeria; 2016. ghdx.healthdata.org/organizations/national-population-commission-nigeria.
12- NPC. National Population Commission. Census, Population and Development Review; 2007; 33: 206-210. http://www.population.gov.ng/index.php/about-npc
13- Babatunde O. Family planning as a critical component of sustainable global development in Nigeria. Global Health Action. 2015; 8: 10.3402/gha.v8.30086.
14- FMOH. Federal Ministry of Health. Lessons on Family Planning Accountability Programming Action 2020 Program, 2015. https://www.familyplanning2020.org/nigeria
15- Anyanwu, J. I, Ezegbe, B.N, Eskay, M. Family Planning in Nigeria : a Myth or Reality ? Implications. Journal of Education and Practice. 2013; 4(15):108–14.
16- Abiodun O, Olu-abiodun O, Ani F, Sotunsa O. Sexual and Reproductive Health Service Utilization among communities in Rural Areas in Nigeria. Journal of AIDS and clinical research. 2016; 7(6).
17- Akanni I, Uche C, Isiugo-Abanihe. Demographic dynamics and development in Nigeria. African Population Studies. 2014, page 240
18- UNFPA. Promoting sexual and reproductive health for persons with disabilities. Guidance note. 2009.https://www.unfpa.org/publications/promoting-sexual-and-reproductive-health-persons-disabilities
19- UNFPA. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. 2018. https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities
20- Hodson, N, Bewley. Social exclusion and human rights at the intersection of HIV and severe mental illness. The Lancet Psychiatry, 2017. 4(12), 898–899.
21- Okpalauwaekwe U, Mela M, Oji. Knowledge of and Attitude to Mental illnesses in Nigeria: A Scoping Review. Integrative Journal of Global Health, 2017. 1(5), 1–14
22- Bakare, M. O., Agomoh, A. O., Ebigbo, P. O., Onyeama, G. M., Eaton, J., Onwukwe, J. U., & Okonkwo,. Co-morbid disorders and sexual risk behavior in Nigerian adolescents with bipolar disorder. International Archives of Medicine. 2009, 2(1), 1–5
23- Armatas, V. Mental Retardation : Definitions, Etiology, Journal of Sport and Health Research. 2014 1(2), 112–1

24- Adyemi, Toyin, Janet. Teachers' perspectives of sexuality and sexuality education of learners with intellectual disability in Niger state. Nigeria.2014
25- Armiyau AY. A Review of Stigma and Mental Illness in Nigeria. Journal of Clinical Case Reports 2015; 5(1):1–3.s
26- Aday LA, Andersen RM. A framework for the study of access to medical care. Health Services Research; .1974. 9: pp 208-20.
27- Andersen, RM. Revisiting the behavioural model and access to medical care: does it matter? Journal of Health Social Behaviour; .1995. 36: pp 1-10.
28- Levesque JF, Sutherland K. What role does performance information play in securing improvement in healthcare? a conceptual framework for levers of change. BMJ Open. 2017;7(8):1–9.
29- Richard L, Furler J, Densley K, Haggerty J, Russell G, Levesque JF, et al. Equity of access to primary healthcare for vulnerable populations: The IMPACT international online survey of innovations. Int J Equity Health [Internet]. 2016;15(1). Available from: http://dx.doi.org/10.1186/s12939-016-0351-7
30- World Health Organizatio.Promoting Rights and Community Living for People with Psychosocial Disabilities.2017. http //www.who.int/ mental_health/world-mental-health-day/2017/en/
31- Tracy be. The impacts of mental disability : implications for social work practice. 2017;7(1):1–8.
32- Ebuenyi ID, Syurina E V, Bunders JFG, Regeer BJ. Barriers to and facilitators of employment for people with psychiatric disabilities in Africa : a scoping review. Glob Health Action [Internet]. 2018;11(1). Available from: https://doi.org/10.1080/16549716.2018.1463658
33- Tunde T. Towards inclusion : the trends of psycho-social adjustment of students in Nigerian integrated junior secondary schools. 2010;5(2):1146–50. Available from: http://dx.doi.org/10.1016/j.sbspro.2010.07.251
34- WHO. World Health Organization Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health*. 2010. https://www.who.int/social_determinants/thecommission/finalreport/en/
35- Lasebikan VO. Profile and Determinants of Disability in Psychotic Disorders in Nigeria. Community Mental Health J. 2016;0(0):0.
36- Federal Republic of Nigeria. Country Report June 2018. 2018 ;(June):1–21. www.fgn.gov.
37- Brooke-sumner C. Perceptions of psychosocial disability amongst psychiatric service users and caregivers in South Africa. 2012;1–10.
38- Etieyibo E, Omiegbe O, Africa S, State D. Religion , culture , and discrimination against persons with disabilities in Nigeria. 2007;(Omiegbe 2001):1–6.
39- Addlakha R, Price J, Heidari S, Addlakha R, Price J, Heidari S. Disability and sexuality : claiming sexual and reproductive rights Disability and sexuality : claiming sexual and reproductive rights. 2017; 8080.
40- Martinello E. Reviewing Risks Factors of Individuals with Intellectual and mental Disabilities as Perpetrators of Sexually Abusive Behaviors. 2015;269–78.
41- Peta C, Peta C. Disability is not asexuality : the childbearing experiences and aspirations of women with disability in Zimbabwe Disability is not asexuality : the childbearing experiences and aspirations of women with disability in Zimbabwe. 2017;8080.
42- Hunt X, Carew MT, Braathen SH, Swartz L, Rohleder P, Hunt X, et al. The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with disabilities in South Africa : beliefs of non-disabled people sexual and reproductive health services of people with physical. 2017;8080(May).
43- Burke E, Kébé F, Flink I, Reeuwijk M Van, May A, Burke E, et al. A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal people with disabilities to access sexual and reproductive health services in Senegal. 2017;8080(May).

44- Aldermen TJ, Pillay BJ. Sexual abstinence and HIV knowledge in school- going adolescents with intellectual and psychosocial disabilities and non-disabled adolescents in Nigeria. 2013; 0583.
45- Baines S, Emerson E, Robertson J, Hatton C. Sexual activity and sexual health among young adults with and without mild / moderate intellectual and mental disability. 2018;1–12.
46- Iheanacho T, Kapadia D, Ezeanolue CO, Alice A, Ogidi AG, Ike A, et al. Attitudes and beliefs about mental illness among church-based lay health workers : experience from a prevention of mother-to-child HIV transmission trial in Nigeria. 2016;2863.
47- Iliyasu Z, Abubakar IS, Aliyu MH. Health and Human Rights village in northern Nigeria. BMC International. 2015; 1–6.
48- Tunde T. Towards inclusion : The trends of psycho-social adjustment of students in Nigerian integrated junior secondary schools. Elsevier. 2010;5:1146–50.
49- Aderemi TJ, Pillay BJ, Esterhuizen TM. Differences in HIV knowledge and sexual practices of learners with intellectual, developmental and mental disabilities and non-disabled learners in Nigeria. Journal of international AIDs society. 2013;1–9.
50- Ofuani AI. Protecting adolescent girls with intellectual disabilities from involuntary sterilisation in Nigeria : Lessons from the Convention on the Rights of Persons with Disabilities. 2017;550–70.
51- Rohwerder, B. Disability Stigma in Developing Countries. K4D Helpdesk Report. Brighton, UK: Institute of Development Studies. 2018
52- Bradshaw, J. The conceptualization and measurement of need: A social policy perspective. J. Popay, G. Williams (Ed.). Researching the people's health. London: Rutledge. 1994. (pp. 45-57).
53- Bradshaw, J. Problems and progress in medical care. A taxonomy of social need. G. McLachlan (Ed.): Essays on current research. London: Oxford University Press. 1972 (pp. 71-82).
54- Finlayson, M. Assessing needs for services. G. Keilhofner (Ed.). 2006. (pp. 591-606).
55- Gilmore, D. G., & Campbell, D, M. Needs and capacity assessment for health education and promotion. 2005. (3rd Ed.).
56- Watkin, B. R., Altschuld, J. W. Planning and conducting needs assessments. A practical guide. Sage Publications. 1995.
57- Mohammed K, Zubair I, Isa S A, Muktar H A. Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. 2004. BMC International Health and Human Rights 2004, 4:3 doi:10.1186/1472-698X-4-3. http://www.biomedcentral.com/1472-698X/4/3
58- Eide, A.H. et al. Perceived barriers for accessing health services among individuals with disability in four African countries.2015. PLoS ONE, 10(5), pp.113.
59- Ahumuza, S.E. et al. Challenges in accessing sexual and reproductive health services by people with disabilities in Kampala, Uganda.2014. Reproductive Health, 11(1), p.59. Available at: http://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-11-59.
60- Mulumba, M. et al.Perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda.2014. International Journal for Equity in Health, 13(76). Available at: http://equityhealthj.biomedcentral.com/articles/10.1186/s12939-014-0076-4.
61- Ganle, J.K. et al.Challenges women with disability face in accessing and using maternal healthcare services in Ghana.2016. A qualitative study. PLoS ONE, 11(6), pp.113.
62- Mprah, W.K. Perceptions about barriers to sexual and reproductive health information and services among people with disability in Ghana.2013. Asia Pacific Disability Rehabilitation Journal, 24(3), pp.2136. Available at: http://www.scopus.com/inward/record.url?eid=2-s2.0-84887188121&partnerID=tZOtx3y1
63- Mavuso, S.S. &Maharaj, P.Access to sexual and reproductive health services: experiences and perspectives of persons with disabilities in Durban, South Africa.2015. Agenda, 29(2), pp.122.

64- Burke, E. et al A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal.2017. Reproductive Health Matters, 25(50), pp.4354. Available at: http://proxy.lib.ohio-state.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=123929381&site=ehost-live
65- Akasreku B Dela, Habib H, Ankomah A. Pregnancy in Disability: Community Perceptions and Personal Experiences in a Rural Setting in Ghana. J Pregnancy. 2018;2018.
66- Ganle JK, Otupiri E, Obeng B, Edusie AK, Ankomah A, Adanu R. Challenges women with disability face in accessing and using maternal healthcare services in Ghana: A qualitative study. PLoS One. 2016;11(6):1–13.
67- Ministry Of Health. Federal republic of nigeria. 2013;(June):1–4. www.fmoh.gov.ng
68- Federal Ministry of Women Affairs and Social Development. National Standards for Improving the Quality of Life of Vulnerable Children in Nigeria. 2014. 1–41 p.
69- Federal Government of Nigeria. National Policy on Population for Sustainable Development. The Western Political Quarterly. 2014. http://www.healthpolicyproject.gov.ng/pub/finalreport.pdf
70- British Council. Improving the lives of girls and women in Nigeria: Issues, policies and action. Gender Nigeria Republic 2012 [Internet]. 2012;1–81. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67333/Gender-Nigeria2012.pdf
71- Olayode, K. Rethinking African Development Africa: A Gender-responsive Governance Agenda in Nigeria. 2013
72- World Bank. Nigeria report. World Bank OpenDdata. 2017; http://data.worldbank.org/country/Nigeria
73- WRAPA. Report on Gender Equality and Women Empowerment in Nigeria: The Place of Affirmative Action. 2008
74- Jack-Ide IO, Uys LR, Middleton LE. Care giving experiences of families of persons with serious mental health problems in the Niger Delta region of Nigeria. International Journal of Mental Health Nursing. 2013;22(2):170–9.
75- AWOTIDEBE TO, BISIRIYU LA, ATIVIE RN, OKE KI, ADEDOYIN RA, NABAKWE EC, et al. Prevalence of physical inactivity among Nigerian women: do socio-demographic characteristics, women's personal attributes and psychosocial factors play any role? [Internet]. 2017;4(1):33–45. Available from: http://search.ebscohost.com/login.aspx?direct=true&db=sph&AN=123361853&site=ehost-live
76- Amusat N. Disability Care in Nigeria: The need for professional advocacy. African Journal Physiotherapyand Rehabilitation Science. 2011; 1(1):30–6.
77- Krahn GL, Walker DK, Correa-De-Araujo R. Persons with disabilities as an unrecognized health disparity population. Am J Public Health. 2015; 105:S198–206.
78- Kleintjes S, Lund C, Swartz L. Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: A qualitative study of perspectives of policy makers, professionals, religious leaders and academics. BMC Int Health Hum Rights [Internet]. 2013;13(1):1. Available from: BMC International Health and Human Rights
79- Odimegwu C, Adedini SA, Ononokpono DN. HIV/AIDS stigma and utilization of voluntary counseling and testing in Nigeria. BMC Public Health. 2013;13(1).
80- Sediqi S. The Impact of addiction on access to sexual and reproductive health. 2019; 16(2018):283–6.
81- Jack-Ide IO, Uys L. Barriers to mental health services utilization in the Niger delta region of nigeria: Service users' perspectives. Pan Afr Med J. 2013;14:159.
82- Victor Olufolahan Lasebikan1 · Olatunde Ayinde. Profile and Determinants of Disability in Psychotic Disorders in Nigeria. Community Mental Health Journal ·2016
83- UNFPA United Nations Population Activities Fund. Developing technical guidance on mental health in sexual and reproductive health. New York, USA.2017

84- DCDD. Dutch coalition on disability and development. Sexual and reproductive health and rights among young people in low- and middle income countries Age groups. 2016 ;(November):1–9.
85- International Community Moves Toward a More Robust Recognition of Both the Women S Rights and Human Right Communities / Ur Objective Is Foremost To Articulate Discriminatory Are Often Silent Where W.
86- Tanabe M, Nagujjah Y, Rimal N, Bukania F, Krause S. Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings : Risks , Needs , and Capacities of Refugees with Disabilities in Kenya ,. Sexuality and Disability. 2015;33 (4):411–27.
87- UNFPA.A Situational Analysis of the Sexual and Reproductive Health of Women with Disabilities. 2009
88- Stock burger S. Women with Disabilities : Reproductive Care and Women's Health. 2015;
89- United Nations Population Fund. Mental, sexual & reproductive health. 2001
90- Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet. 2018;391 (10140):2642–92.
91- Brooke-sumner C. Perceptions of psychosocial disability amongst psychiatric service users and caregivers in South Africa. 2012;1–10.
92- Martinello E. Reviewing Risks Factors of Individuals with Disabilities as Perpetrators of Sexually Abusive Behaviors. 2015;269–78.
93- The Wisconsin Women's Health and Family Planning / Reproductive Health Program Services. 2016;
94- National Reproductive Health Policy of Nigeria. 2017. https://riseuptogether.org/wp-content/uploads/2018/05/C4C_Nigeria_-_National_Reproductive_Health_Policy.pdf
95- Tun W, Okal J, Schenk K, Esantsi S, Mutale F, Kyeremaa RK, et al. Limited accessibility to HIV services for persons with disabilities living with HIV in Ghana, Uganda and Zambia. J Int AIDS Soc. 2016;19(Suppl 4):1–7.
96- Lin, L., Lin, J., Chu, C. M., & Chen, L. Caregiver attitudes to gynaecological health of women with disability. Journal of Intellectual and Developmental Disability.2011.36(3), 149-155
97- Lin, L., Lin, P., Chu, C. M., & Lin, J. Predictors of caregiver supportive behaviors towards reproductive health care for women with disabilities. Research in Developmental Disabilities.2011.32 (2), 824-829.
98- Handlin O, Handlin O. Worlds Apart. The Distortion of America. 2018. 205–216 p.
99- Miller, H. L., Pavlik, K. M., Kim, M. A., & Rogers, K. C. An exploratory study of the knowledge of personal safety skills among adult with disabilities. Journal of Applied Research in Intellectual and mental Disabilities. 2017. 30(2), 290-300.
100- Van der Stege, H. A., Hilberink, S. R., Visser, A. P., & Van Staa, A. L. Motivational factors in discussing sexual health with young people with chronic conditions or disabilities. Sex Education.2014. 14(6), 635-651.
101- McCarthy, M. Prescribing contraception to women with intellectual and psychosocial disabilities: General practitioners' attitudes and practices. Sexuality & Disability. 2011. 29(4), 339-349.
102- Edgardh K. Adolescent health in Sweden. Sexually Transmitted infection.2002.78:352-6
103- Tyden T NordenL, Ruusuvanara L, Swedish adolescent knowledge of sexually transmitted diseases and their attitude to condom use. Midwifery.2009:725-30
104- CDDH. Centre for Developmental Disability Health. Victoria' www.cddh.monash.org/2010
105- Cook, J. Sexuality and people with psychiatric disabilities.' Journal of sexuality and Disability. 2011.Vol 18 (3) pp 195-206
106- AAIDD. Sexuality & Intellectual Disability.' www.aamr.org./content_198.cfm.2012

107- WHO. Mental health aspects of women's reproductive health. World Health Organization, 2018. 61(4), 1–7
108- Aigbovo, O. and Atsegbua, L. , "Nigerian anti-corruption statutes: an impact assessment", Journal of Money Laundering Control, 2013. Vol. 16 No. 1, pp. 62-78. https://doi.org/10.1108/13685201311286869
109- Lang, R., Upah, L. Scoping Study: Disability Issues in Nigeria, 2008, http://www.iss.co.za/Af/profiles/Nigeria/Politics.html
110- The Intersection of Disability and Gender in the Global South: Narratives, Gaps and Opportunities - CBM UK. 2018
111- BSC Uzochukwu, MD Ughasoro, E Etiaba, C Okwuosa. Health care financing in Nigeria: Implications for achieving universal health cover. 2015 Vol. 18 (4) 437-444

ANNEX1: SEARCH TABLE

<table>
<tr><td>Search strategy</td><td>Objective 1</td><td>Objective 2</td><td colspan="2">Objective 3</td><td>Objective 4</td></tr>
<tr><td></td><td colspan="5">Key words</td></tr>
<tr><td>VU library</td><td></td><td></td><td rowspan="5">Sexual, Reproductive,health, Rights, Women,Pregnancy, HIV Maternal Health, Family, planning, Reproductive, Health, Adolescent, sexual,Sub-Saharan Africa</td><td rowspan="5"></td></tr>
<tr><td>Pubmed</td><td></td><td></td></tr>
<tr><td>Google Scholar</td><td></td><td></td></tr>
<tr><td>Regular Google for grey literatures, websites of government like FMoH, NACA,UN agencieslike UNFPA, UNAIDS,WHO ,andotherorganizationslikeIPPF, GNP+,APN+, ICW</td><td>SRHR, Programs, interventions; policy advocacy, strategic plans, Report, Survey, PMTCT, HIV, Nigeria, Sub-Saharan Africa, Incidence, Prevalence

"AND"

"OR"</td><td>Persons, psychosocial, Women, disability, service, sexual reproductive health rights, women HIV, pregnancy, condom, gender, , abortions, unintended, access, services, Risks, Factors, Determinants, Influencing, Affecting, Barriers,

"AND" "OR"</td><td></td></tr>
<tr><td>Bibliography</td><td></td><td></td></tr>
</table>

of selected articles				