



An exploration of barriers and enabling factors for young people with disabilities to access sexual and reproductive health services in Senegal

Final Report



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The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.

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Summary

Background

In Senegal, recent initiatives have sought to prioritise young people in national sexual and reproductive health (SRH) plans. Commitments have also been made to uphold the health rights of people with disabilities. Young people are at an increased risk of unplanned pregnancies and sexually transmitted infections (STIs) due to lack of information and use of SRH services. Young people with disabilities (YPWD) face the same vulnerabilities and barriers as other young people, but face additional vulnerabilities related to their disability. Health care facilities and health workers play a key role in mediating young people's risk but can also reinforce barriers to health services for young people. Little research has been done in Senegal to understand the motivation and the barriers faced by YPWD and health workers.

Objectives

The objective of the study was to inform the development of the most effective strategies for increasing the uptake of contraceptive and other SRH services among YPWD in Senegal. In order to achieve this objective, the following were explored:

- The knowledge and attitudes to SRH services by YPWD;
- The challenges they face in accessing SRH services;
- Their preferences for where to access SRH services;
- The opportunities for access to such services through the private sector.

Methodology

A total of 17 focus group discussions and 50 interviews were conducted with young men and women with either a physical, visual or hearing impairment between the ages of 18-24 years in Dakar, Thies and Kaolack. A total of 8 private providers were sampled in Phase 2; 4 were SRH information providers and 4 were SRH service providers.

Results

Respondents were commonly in relationships and nearly half reported having had sexual intercourse. Multiple cases of rape were reported, predominantly amongst women with hearing impairments. Contraceptive knowledge and use was relatively low and often limited to condoms, with never use of contraception amongst several respondents. Gender norms resonated about preserving female virginity until marriage. Low use of SRH services were reported by YPWD. Main factors influencing use of a service included confidentiality, anonymity and proximity. Main barriers to access for YPWD were financial barriers, provider attitudes, parent attitudes, and accessibility (physical and communication barriers). Private providers highlighted the need for SRH information and services for young people, and demonstrated an understanding of the importance of confidentiality and provider attitudes, yet lacked specific strategies to target YPWD, compounding the non-use of these services by respondents in Phase 1.

Discussion & recommendations

YPWD are uninformed about where to access SRH services and face multiple additional barriers in accessing such services, contributing to their very low use. Specific demand and supply barriers must be addressed to respond appropriately to their varied needs. There is an urgent need for more evidence and support for victims of sexual violence. Interventions to increase access to services must take disability-specific barriers and gender norms into consideration. The introduction of the *cartes d'égalité des chances* presents an opportunity to overcome the financial barriers to access SRH services, but must be made redeemable in appropriate in youth and disability-friendly health facilities for uptake of services to increase. Private providers could respond to YPWD' needs, as many have interventions and the infrastructure in place to do so, but training of providers and targeted interventions are required to respond appropriately.

Introduction

Young people, defined as 10 -24 years old¹, represent 33% of the population in Senegal². Despite onset of sexual activity during adolescent years for many young people – 40% of girls and 20% of boys³ - young people make relative little use of sexual and reproductive health services, and as a result are at an increased risk to unplanned pregnancies and sexually transmitted infections (STIs).

Young people are not a homogenous group and responding to their SRH needs remains a challenge for public health interventions. Young people with disabilities (YPWD) have distinct health needs as well as socio-economic challenges which must be taken into consideration. People with disabilities can often have an unmet need for SRH services, as a result of exclusion from SRH services, lack of capacity of health providers to meet their needs, or are often (mis)perceived as not being sexually active⁴. Little has been researched and documented in Senegal about the accessibility of SRH services amongst youth and even less so about those living with disabilities. Government policies are in place that recognise young people as a priority group for achieving SRH goals, and commitments have been made to ensure the health rights of people with disabilities are upheld. What remains to be explored is whether the policy environment enables access to SRH services in practice. This report seeks to explore what their needs and behaviour practices are in relation to SRH services, as well as the barriers faced in accessing them.

The ASK Programme was introduced in Senegal in 2013, with an aim of enhancing the uptake of SRH services among young people aged between 10-24 years. The ASK Programme is led by ASBEF and Amref Health Africa, with technical assistance from Centre Ginddi. The programme places a strong emphasis on reaching under-served and hard-to-reach groups, including Talibé, YPWD and young people from extremely poor urban families, as well as meaningful participation of young people in research and intervention development.

Sexual and reproductive health of young people in Senegal

Young people's experience of SRH care and their exposure to risks in Senegal is not uniform, with multiple social and economic factors differentiating their SRH risks and access to services. A young person's age, sex, education, marital status and exposure to family life education have also been demonstrated in studies to play a role in their ability to access SRH services^{5 6}.

Previous studies^{7 8 9} on young people's access to SRH information and services in Senegal revealed that while levels of correct knowledge about HIV are fairly high among young people in the general population, knowledge about other SRH issues remains very low, especially related to contraception and menstruation. A range of barriers to accessing SRH products, information and services have been identified in both published and unpublished literature. Young people report that affordability of SRH services¹⁰, convenient opening times¹¹, uncertainty of whether they are

allowed to access key SRH services before the age of 18 years old¹² and lack of confidence that pharmacists and clinicians will preserve confidentiality and provide services in a non-judgemental manner¹³ all play a role in poor demand for SRH services. A simulated client study revealed young people's experience of embarrassment or fear of using SRH services, and young unmarried women were often refused contraception by providers¹⁴. Provider attitudes can have a detrimental effect on access to SRH services and products^{15 16 17}. In Senegal, studies show that only 65% of providers think that the emergency contraceptive pill should be provided to single teenagers and young women¹⁸ and that many providers restrict young peoples' access to contraception according to their age (to a medium minimum age of 18 years), and their marital status¹⁹.

Young people with disabilities in Senegal

The exact number of YPWD in Senegal is unknown, but an estimated 5.9% of the population in Senegal is living with a disability, approximately 800,000 people²⁰. According to national studies, the most common form of disability is a physical disability, followed by a sensory, mental, or multiple disabilities^{21 22}. People living with a disability are less likely to be employed and in education, and therefore at risk of greater poverty levels^{23 24 25}, potentially exacerbating their financial barriers to healthcare and other basic services. A Ziguinchor-based study revealed that 7.2% of people with disabilities reporting had regular income, 27.8% irregular income, and 55% no income²⁶. Access to education remains low; with nearly half (49.7%) of children with disabilities not attending school, of which 65.8% had never attended school and 34.2% had dropped out²⁷.

Despite efforts to improve rights to education, health, employment and public services, people with disabilities in Senegal continue to face disproportionate disadvantages compared to the rest of the population: 3 out of 4 people with disabilities cannot read or write, health facilities and public buildings cannot physically accommodate them, and only 21% of those of working age have access to employment²⁸. YPWD face a double-burden in accessing SRH services – their age and barriers related to their disability, including lack of information, social exclusion, financial barriers, difficulties with communication and physical access to health facilities²⁹, coupled with economic, social, and cultural barriers³⁰. As a result, their health-seeking behaviour is affected, with those with disabilities being reluctant to seek health care because of stigmatization and discrimination related to their disability³¹.

Risk of sexual and gender-based violence is greater for people living with disabilities^{32 33}, increasing their need for access to SRH services, and legal and support mechanisms. One study found that 9.3% of women and 3.4% of men with disabilities in Ziguinchor reported coerced sex during their first sexual encounter³⁴. There is very limited research on the SRH of YPWD in Senegal, but studies conducted by Handicap International^{35 36} revealed that nearly half of respondents had had sex by the age of 19 years, they had good knowledge of condoms but low use of them, only 21% of people used any form of contraception at first sex, and HIV prevalence was higher amongst them than the national average, compounded by many misconceptions about HIV transmission modes.

SRH policy environment for young people and people with disabilities

Young people's sexual and reproductive health and rights (SRHR) are an increasingly recognized priority by the Government and civil society in Senegal, evidenced by the 2005 Reproductive Health Law, which articulates the importance of improving access to quality SRH information and services for adolescents and young people. The current National Health and Development Plan³⁷ outlines a minimum package of SRH services that should be available in all public health facilities to prevent unintended pregnancies and the transmission of STIs, among young people; whilst the 2012-2015 National Family Planning Action Plan³⁸, identifies young people as a priority group for achieving a 27% contraceptive prevalence rate by 2015.

The Senegalese Government has made commitments to supporting people with disabilities over the past decade. Senegal signed the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2007, which was formally ratified in 2010³⁹, guaranteeing "that persons with disabilities enjoy legal capacity on an equal basis with others (Article 12), have the right to marry and found a family and retain their fertility (Article 23), and have access to sexual and reproductive health care (Article 25)"⁴⁰. In 2010, the National Assembly voted in a Social Orientation Law that guarantees "equal opportunities for people with disabilities and the promotion and protection of their rights against any form of discrimination"⁴¹. One of the key commitments outlined in the law was to provide equal opportunities cards ("*carte d'égalité des chances*") for people with disabilities that would entitle them to access subsidised healthcare and transport, and support their access to education, training, and employment. These cards were finally launched in April 2015 and the Government committed to distributing 50 000 cards by 2017.

Provision of sexual and reproductive health services in Senegal

Providing appropriate SRH information and services to young people is essential for maintaining their SRH status and protecting them from adverse consequences such as unplanned pregnancies, STIs and HIV. Health providers can be enablers or barriers to the provision of such services, but little research has explored the reasons behind attitudes and motivation of providers themselves.

Young people make use of both the private (both profit and non-profit) and the public sectors to access their SRH services, but the relative use of public and private sectors differs dramatically according to the type of service or product sought. A 2014 study revealed that 33% of young women obtained their contraceptive method in the private sector or NGOs; with large differentials according to what method was obtained- for example, over 95% of young people who use the contraceptive implant accessed the method in a public facility, but amongst those using condoms, only 5.2% of young people accessed the method in a public facility⁴². The private sector is a major part of the health system in Senegal and recognised by the Government as a key contributor to reaching national SRH objectives.

Public-private partnerships to increase access to SRH services for young people are a core focus area for the ASK Programme. Furthermore, given the potentially major role that private sector (such as private providers, pharmacies, or non-governmental organisations) plays in the provision of certain SRH services to young people, further exploration of the care-practices of private sector providers is required to identify the specific motivational, infrastructural, financial and other barriers that private providers themselves face in providing services for young people, including those with disabilities.

Objectives

The overall objective of the study was to document the most effective strategies for increasing the uptake of contraceptive and other SRH services among YPWD in Senegal. In order to achieve this objective, the following sub-objectives were explored:

1. To document the knowledge of and attitudes to SRH services by YPWD;
2. To document current challenges YPWD face to access SRH services;
3. To identify which SRH services YPWD want and where they want to access them;
4. To document barriers and opportunities for access to SRH information and services through the private sector.

Data generated from the study will be used to:

- Inform operational strategies of the ASK Programme partners and other providers working with young people, including those with disabilities, to respond to the SRH needs of young people;
- Inform the Government, civil society organisations, and policy makers on the challenges YPWD identify in terms of access to SRH services;
- Identify private providers that ASK partners or other organisations could partner with to increase access for YPWD to comprehensive SRH services;
- Share lessons learned and replicate the successes of the providers from which young people are accessing the SRH services that they need;
- Create an enabling environment for young people to participate in research.

Definitions

As per the CRPD, people with disabilities in this report are defined as those who have “long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”¹.

People with disabilities in this report, are split into three specific groups:

- Physical impairment: limitation of the physical function of limbs, fine bones, or gross motor ability is a physical impairment
- Hearing impairment: partial or total hearing loss
- Visual impairment: partial or total sight loss

Sexual and reproductive health services referred to in the report are derived from the package of youth-friendly services defined by IPPF in their 2008 publication “Springboard: A hands-on guide to developing youth-friendly centres”:

- SRH counselling (providing information, support and advice, including sexual abuse and relationship counselling)
- Contraceptive provision (including emergency contraception)
- Sexually transmitted infection/HIV prevention, testing, counselling, treatment and care
- Pregnancy testing
- Safe abortion and/or post abortion related services
- Pre- and antenatal care (services relating to pregnancy and birth)
- Information, education and communication (IEC) activities, and behavioural change communication activities such as quizzes, debates and workshops

The “private sector” in Senegal comprises largely of private-run clinics, pharmacies, and non-governmental organisations (NGOs). The private sector can be for-profit (in the case of many private-run clinics, pharmacies) or not-for-profit (in the case of NGOs). The sample from the private sector in this study have been divided into two distinct categories in this report:

- 1. Service providers:** private sector clinics or organisations providing a range of SRH services;
- 2. Information providers:** private sector groups or organisations providing a range of information, support and advice on SRH but do not provide SRH services.

¹ UN, 1996, Article 1, Convention on the Rights of Persons with Disabilities

Methodology

Type of Study

The study was split into two Phases – 1) gathering perspectives of YPWD’s access to SRH services; and 2) exploring the perspectives and opportunities of the private sector in providing SRH services to YPWD. The study was qualitative, consisting of focus group discussions and/or in-depth interviews.

Phase 1

A peer approach was applied where YPWD were identified and trained as data collectors. This was achieved using two methods:

1. **Focus groups** were organised around a topic guide that emphasised overarching themes and general experiences YPWD had in relation to sexuality, SRH and access to services and products.
2. **In-depth interviews** were structured around a narrative history of a young person’s sexuality from puberty onwards and their interaction with SRH services.

Focus group participants were grouped by sex and according to each disability: physical, visual or hearing. Each focus group had a maximum of 8 young people participating. To explore the experience of young disabled people in greater depth, at least 2 people from each focus group were invited to participate in an in-depth interview.

Phase 2

In-depth interviews were conducted with a select group of private providers providing SRH information and services to explore what they thought were the barriers faced by young people, the opportunities for the private sector to provide services, and what good practices have proved successful to date. Interviews followed a topic guide structured around key themes relating to service provision or product distribution to young people, including those with disabilities. Findings from Phase 1 were incorporated into the topic guide for the interviews in Phase 2.

Ethical considerations

Prior to conducting the study, ethical approval was obtained from the local ethics committee for health research in Senegal- the *Comité National d'Éthique pour la Recherche en Santé* (CNER). Permission was requested from, and a letter of support was issued by, the Division of Private Medicine at the Ministry of Health and Social Action to invite private providers and organisations to participate in Phase 2.

Informed consent forms were signed by young people and private providers prior to participating in focus groups and interviews.

Data collectors

Youth participation is a central pillar of the ASK Programme. A core component of this research is that young people (peers) were trained to conduct the focus group discussions and interviews with young participants. A 4-day workshop was organised to build the capacity of the young participants in qualitative research skills following the EXPLORE toolkit⁴³, developed by Rutgers and the International Planned Parenthood Foundation, to enhance youth participatory research techniques. This was followed by a 1.5-day workshop on qualitative data analysis and reflections workshop.

YPWD were recruited to collect the data in Phase 1 to create a more comfortable and relevant environment for the study participants. For collecting data from people with hearing impairments, young people who could do sign language were recruited.



Training and data collection methodology were adapted to respond to the group's different disability needs. Data collectors were paired up for focus group discussions, where in the case of a data collector with a visual impairment, note taking during a focus group discussion was done by a note taker without a visual impairment. Focus group and interview topic guides were translated into braille and/or pre-recorded onto dictaphones for those with visual impairments. Focus group discussion and interview guides for Phase 1 were piloted during the training and revised accordingly.

In total 14 people were recruited and trained of which 3 were visually impaired, 9 were living with a physical impairment, and 2 did not have a hearing impairment but were experienced in communicating with people with hearing impairments and could do sign language. There were 6 female and 8 male data collectors. One female data collector with a physical impairment completed the training but did not participate in data collection.

Each data collector participated in a reflective process about their role. This was done through:

- ✓ Kept a personal journal which was completed each day of data collection;
- ✓ Developed an I-poem based on their journal; and
- ✓ Completed a questionnaire about their experience based on their journal.

Data collection in Phase 2 was conducted and transcribed by the Research Supervisor.

Study population

The study was split into two Phases – 1) gathering perspectives of YPWD's access to SRH services; and 2) exploring the perspectives and opportunities of the private sector in providing SRH services to YPWD. The study was qualitative, consisting of focus group discussions and/or in-depth interviews.

Phase 1

The study population was young people aged 18 – 24 years, living with a physical or sensory (visual or hearing) impairment. Young people under the age of 18 would require parental consent to participate in the study, by Senegalese law. Given the nature of sensitivity of the study topics, young people under the age of 18 years were not invited to participate, unless they were emancipated. Participants were required to be able to communicate verbally or through sign language. Purposive sampling was used to identify the participants for focus groups, from a sampling frame established in collaboration with associations working with people with disabilities in different regions, including the National Association of Motor Disabilities, the Association of Women with Disabilities, the Association for the Blind, and the Association for the Deaf.

The research was conducted in four of the seven ASK Programme project sites: Dakar, Guediawaye, Thies and Kaolack. Dakar was selected as a site as it has the largest concentration of health services and providers, as well as the largest representation of associations of people with disabilities. Thies and Kaolack were selected as these regions have important densities of population in urban areas but vast rural areas with limited access to healthcare facilities. Thies and Kaolack also have active associations working with people with disabilities.

Phase 2

The study population for Phase 2 were private SRH service or information providers or organisations. The sampling frame included any service or information providers identified by YPWD in Phase 1, but as few providers were specifically named during Phase 1, the sampling frame was completed with purposive sampling of providers and organisations already working in the field of SRH information and/or services. Five service providers and six information providers were invited to nominate one team member to participate in the interview, of which 8 were based in Dakar, 1 in Thies and 2 in Kaolack.

Data collection, processing and analysis

Phase 1

At the end of each day of data collection, the data collectors debriefed with the research supervisor. After each focus group discussion or interview, data collectors would complete a short questionnaire to document the key findings, observations of the participant(s), whether any topics were difficult to discuss with the participant(s), and to reflect on how they thought their role may have influenced the data collection. Together the research team selected the key passages of interviews verbatim for full transcription by the data collectors. Each data collector also kept a research diary detailing their experience during the process.

Transcripts were analysed line-by-line in a desk-based analysis by the research team to identify labels and relevant quotes that represent interesting or common topics from both the focus group discussions and interviews. These labels, or codes, were then analysed to identify key concepts that can be constructed and identified that represent recurring themes or noticeable anomalies. They were then organised around a pre-defined qualitative data analysis framework, to draw out key themes and findings. The researchers paid special attention to identifying additional themes – or meta-codes – that emerge from the research that were not part of the pre-defined framework.

During the 1.5-day analysis workshop, the data collectors analysed a selection of their data. The findings of this workshop, including the key meta-codes or themes generated, were compared with the researchers' desk-based analysis. This served to verify each set of codes established in the desk-based and the workshop analysis, but also to identify additional codes.

Codes were initially analysed around a pre-defined set of key themes :

- *SRH over the life course of a young person living with a disability*
- *SRH Knowledge*
- *Attitudes about sexuality and SRH*
- *Perceived self-efficacy over SRH (autonomy)*

- *Influences on SRH behaviours*
- *Influences on SRH service consumption behaviours*
- *Mitigation strategies and innovations*

- *Challenges to access SRH services*
- *SRH service consumption preferences*
- *Drivers of SRH service consumption preferences*

Other key themes arising from the research were added to the analytical framework as they arose during the analysis of codes. The analysis compared and contrasted the emerging themes amongst different disability groups to find common or diverging barriers and opportunities to accessing SRH services and mitigation strategies to barriers identified across sex and disability group.

At the end of the analysis, data collectors' reflexions were extracted from their journals, and analysed in comparison to the data collected (triangulation) and to understand what the experiences were of the data collectors during the process.

Phase 2

The Phase 2 analysis followed a similar structure to the analysis of Phase 1, but the analysis was purely desk-based and conducted only by the core research team. Transcripts were analysed line-by-line by the researcher to identify labels and relevant quotes that represent interesting or common topics from the interviews. These labels, or codes, were then analysed to identify key concepts and where possible concepts that represent recurring themes or noticeable anomalies between or within providers' accounts. These codes were then organised around a second pre-defined qualitative data analysis framework, to draw out key themes and findings. The researchers paid special attention to identify additional themes – or meta-codes – that emerge from the research that added to the understanding of the motivations and external barriers faced by service and information providers in relation to offering SRH services or products to young people.

Interview questions focussed on young people in general, and followed up by questions specifically on YPWD. This allowed the interviewer to have an insight into what services are currently available for young people more broadly, to be able to assess what future opportunities there could be for YPWD.

Codes were initially analysed around a pre-defined set of key themes :

- *Attitudes about young people's sexuality and SRH*
 - *Motivation to provide SRH services*
 - *Key influences on attitudes and motivation*
 - *Motivation to change practice or infrastructure to enable provision*
-
- *Experience providing SRH services to young people (and with disabilities)*
 - *Challenges to providing SRH services*
 - *Current and previous mitigation strategies and innovations to enable provision*
 - *Referral or non-referral practices for young people with disabilities*

Other key themes arising from the research were added to the analytical framework as they arose during the analysis of codes.

Results

Data collection took place in June 2015 for Phase 1 and October 2015 for Phase 2.

Phase 1

In total, there were 17 focus group discussions and 50 interviews conducted, 34 of which were with participants of focus group discussions. The remaining 16 interviews were largely with participants that were not sufficient in number at certain sites to conduct a focus group discussion, so interviews were conducted instead.

Table 1: focus group discussions and interviews by region and disability

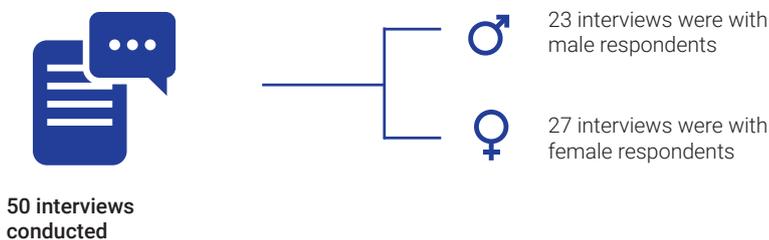
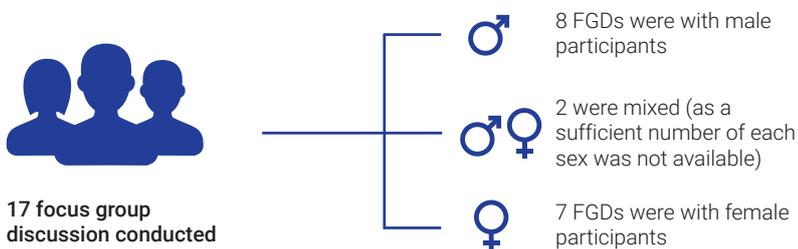
	Dakar	Thiès	Kaolack	Total	
Focus group discussions (FGDs)	Number conducted	11	5	1	17
	By disability	2 visual 5 hearing 4 physical	3 visual 2 hearing	1 physical	
Individual interviews (with FGD participants)	Number conducted	22	10	2	34
	By disability	4 visual 10 hearing 8 physical	6 visual 4 hearing	2 physical	
Other interviews (non-FGD participants)	Number conducted	8	5	3	16
	By disability	8 visual	5 physical	3 visual	

Phase 2

In total, there was a response rate of 72% with 4 service providers and 4 information providers agreeing to participate in the study- of which 6 were in Dakar and 2 were in Kaolack. Participants in Phase 2 represented the following organisations working in SRH information/advice/support: One World, Resopopdev, Centre Ginndi, and Aprofes, and the following health facilities or organisations working in provision of SRH services: Marie Stopes International Senegal, ASBEF, Acdev, and Clinique Oumou Ndiaye. All but one provider interviewed represented a not-for-profit organisation, and the one clinic that could be categorised as “for profit” does provide some subsidised or free services. One information provider represented a public-private partnership, where they were an established public sector entity but partially funded by a private sector project. A total of 9 interviews were conducted - one member from each participating facility or organisation was interviewed, except for one case where two team members from one organisation were interviewed. Each respondent worked directly with young people in their role, ranging from youth programme coordinators to midwives.

Demographics of respondents

Study participants in Phase 1 were aged between 18 and 24 years.



In Phase 2, 6 study participants were male and 3 were female.

Overview of key findings

The main themes that emerged from the data collection in Phase 1 were grouped under the following global categories: sexual activity, contraception, sources of advice and information, and SRH services. The table below depicts the key themes, codes and findings from the research. For more detail on each finding, see further below.

Table 2: Key findings from Phase 1 by theme

Theme	Codes identified	Summary of key findings
Sexual activity & relationships	<ul style="list-style-type: none"> • Sexual debut • Sexual experience • Perceptions of sexual activity • Sexual violence/ rape 	Two-thirds of interview respondents were in relationships, and most have had sexual experiences, with nearly half having had sexual intercourse. Multiple cases of rape were revealed, especially amongst women with hearing impairments.
Contraception	<ul style="list-style-type: none"> • Knowledge • Use • Attitude to contraception 	Low knowledge about the range of contraceptive methods; condoms most widely known and used. A third of sexually active respondents had never used a contraceptive method in their life. Some negative perceptions of contraceptives and their use by unmarried and married women, grounded in social and gender norms (see below).
Gender norms	<ul style="list-style-type: none"> • Attitudes to sex and contraception • Gender of confidants and 	Marriage was considered an important factor- especially for women-for the onset of sexual relations, with only 1 unmarried woman reporting having had sex, and judgemental attitudes to women who engage in sex before marriage. Men more open about sharing sexual experiences and reporting sex outside of marriage. Fathers absent as support mechanism; more women and men report female family members as confidants.
Source of advice / information	<ul style="list-style-type: none"> • Confidants (puberty / relationships / SRH) • Non-confidants • Other sources 	Most respondents confided in no one regarding puberty. Friends, followed by family members, were the most important confidants for relationship advice. Fathers' role as confidant absent. Non-confidants were one or both parents due to fear of parents or embarrassment discussing a taboo subject.
Support networks	<ul style="list-style-type: none"> • Support needed • Support provided 	Identification of accompaniment needs /reliance on others to access health services, especially for hearing and visual impaired. Family members and friends key providers of support.
SRH Service	<ul style="list-style-type: none"> • Knowledge of SRH services • Levels of access • Frequented places for services • Factors influencing choice • Preferred place to access • Barriers • Overcoming barriers 	Low knowledge and use of SRH services. Main factors influencing choice of a service: confidentiality, anonymity, and proximity. Preference of where to access services was divided, but perception of better quality services and care in the private sector, but lower cost services in the public sector. Main barriers to access were financial costs and provider attitudes, as well as parents' attitudes, physical access and communication barriers (for hearing impaired). Rare mention of access to and use of the <i>carte d'égalité des chances</i> .

The main themes that emerged from the data collection in Phase 2 were grouped under the following global categories: SRH strategies, perceived enablers by providers of access to SRH services, inclusion of YPWD, contraception, barriers to SRH services, and opportunities for the private sector. The table below depicts the key themes, codes and findings from the research. For more detail on each finding, see further below.

Table 3: Key findings from Phase 2 by theme

Theme	Codes identified	Summary of key findings
SRH Strategies	<ul style="list-style-type: none"> • Current strategies • Future strategies • Referral mechanisms 	Information providers providing information and support to young people include phone and SMS advice lines, peer education approaches, and community-based information, education and communication. Non-service providers refer young people to local public or private facilities. Service providers offering SRH services in clinics, sometimes in youth-specific clinics and with young service providers, providing free services, or opening at more appropriate times.
Perceived enablers by providers of access to SRH services for young people	<ul style="list-style-type: none"> • Enabling factors • Youth friendly services 	Non-judgemental provider attitudes, confidentiality and affordable services perceived by all as the main enablers. Very few service or information providers had received formal training in youth friendly services; none reported being trained on YPWD.
Inclusion of YPWD	<ul style="list-style-type: none"> • Experience of providing services to YPWD • Specific strategies for YPWD • Attitude towards YPWD 	All service and information providers (except one information provider) reported providing SRH information and services to YPWD. Only one service provider has a specific strategy in place to work with YPWD; all others expressed willingness to provide services to YPWD but do not have targeted strategies.
Use of SRH services	<ul style="list-style-type: none"> • Use of SRH services by young people and YPWD • Use of contraception by young people and YPWD • Provider attitudes to contraception 	Frequent use of SRH information and services by young married and unmarried people, to a lesser, or unknown, extent by YPWD. Main contraceptive methods used by young people are short term methods, including emergency contraception. No discrimination against young people and informed choice of contraceptive method echoed by most. Some mixed messages on what the most appropriate contraception for young people and YPWD by two information providers who primarily encourage abstinence.
Rape cases	<ul style="list-style-type: none"> • Experience of dealing with rape cases • Extent of rape cases • Management or referral of rape cases 	Service and information providers report experience of dealing with rape cases on a monthly basis. Only two information providers have the capacity to support and accompany rape cases, all others refer to social services.

Use of SRH services

- Barriers for young people/ YPWD
- Financial barriers
- Overcoming barriers

Financial barriers and provider attitudes recognised by all as the key barriers for young people to access SRH services. Taboo, religion, socio-cultural norms, and stigma also considered important barriers for young people, and accessibility for YPWD. Young people need more readily available access to SRH information, and ensure services are youth friendly where providers are trained, and opening hours are flexible.

Opportunities for the private sector

- Private sector advantages
- Successful strategies
- Lessons learned

Private sector considered more flexible, able to provide services at more appropriate hours and within a reduced waiting time. Private sector providers can help young people overcome financial barriers to SRH services.

Detailed key findings

Key findings presented below are from Phase 1 and 2. Findings on similar themes have been grouped.

Relationships & sexual activity of young people with disabilities

The majority of interview respondents from Phase 1 reported being in a relationship; 33 were in relationships (66%), of which 6 women and 2 men were married.

The topic of individuals' sexual experience was rarely raised during the focus group discussions; but explored more in-depth during interviews. The majority of respondents reported having engaged in some form of sexual activity, even if this was not sexual intercourse, but alluded to flirtations and petting. Twenty-three (46%) interview respondents reported having had sexual intercourse; with more men than women reporting sexual experience (17 vs 6). Amongst the women, 5 of the 6 who had had sex were married.

In several cases, marriage was an important factor linked to the onset of sexual activity, with several respondents reporting the onset taking place after marriage:

"The first man to be on me will be my husband, but never another" (female, 21, physical impairment)

Many YPWD reported not having any concerns about sex and relationships. For those that did, their main fears and concerns were regarding unplanned pregnancies and sexually transmitted infections (STIs), with male respondents largely expressing these concerns. Outlier responses included fears of the financial costs related to having a child, and concerns about how their physical disability could impede sexual activity. Some participants opposed the perceptions that people have of them not being sexually active or able to have children because of their disability:

“

I live with a disability but this is not an obstacle to having sexual relations and bearing children

”

(female, 25, hearing impairment)

“People think that we are all well-behaved but we have sexual desires just like everyone else”
(male, 23, visual impairment)

Service and information providers in Phase 2 confirmed that young people are sexually active and seeking their SRH information and services, including contraception. All private providers are providing information and services to young people, and all but one report that this includes YPWD. One service provider has a specific strategy on working with YPWD which includes a peer education approach and making health centres more accessible. Other service providers do not have specifically accessible clinics (e.g. with ramps for people with physical impairments) but accommodate YPWD as best they can, and try to make their services as youth friendly as possible by having young service providers, providing SRH services for free or by redeeming a voucher for a free service, or having more flexible opening times that allow young people to come after school hours, or at a time specifically allocated to young people to maximise confidentiality. Information providers do not have disability-specific information, and often do not know if the recipient is living with a disability or not as communication is via the phone or SMS. One information provider offering a confidential SMS service to young people expressed an interest and willingness to adapt their current technology to ensure it is accessible to all types of disability. The only case where an information provider does not provide a direct service to a YPWD was where they referred YPWD on to specific associations working with this group.

Sexual Violence

During both the focus group discussions and the interviews in Phase 1, experiences of rape and sexual violence were revealed by female participants. Three cases of rape were shared during the focus group discussions, and during the individual interviews, 5 women reported having been raped. **Experience of rape was common amongst women with hearing impairments** who were 4 of these 5 cases (the 5th had a physical impairment), out of a total of 7 women with hearing impairments who were interviewed. In one case, a respondent revealed she was raped 6 times. All rape incidences took place when the women were adolescents or younger, and perpetrators were often family members or family friends, and in one case a worker in a professional facility. Only one reported seeking medical help following the rape. Women spoke of their fear to disclose these incidences, and the impact it has since had on them:

“

I have never been in love. I was raped in 2008 by my uncle's friend. Since then I have been distrustful...I have never had sexual relations apart from the rape...I am scared that I will be raped again. That's the reason I don't dare have a boyfriend

”

(female, 22, physical impairment)

“I didn't sleep because of the story about rape”
(female data collector, journal extract)

Service and information providers confirmed cases of rape of young girls, and in some cases young boys, seeking their services. Most service and information providers do not have the capacity to manage rape cases themselves – this could be because they do not have a qualified psychologist on their team, or the legal/judiciary skills to manage such a case. In these cases, they refer the young person to social services or to NGO networks who can provide the necessary support. Two information providers manage rape cases themselves; in one case, the provider houses rape victims whilst the judiciary process is underway, and in the other case, the provider works with a gynaecologist to provide evidence of a rape case and launches the judicial process.

Contraceptive knowledge and use

When YPWD were asked what contraceptive methods they knew, most focus group discussions named at least 3 modern methods, of which condoms were consistently cited across all groups. A significant lower knowledge of the range of methods was apparent in the focus group discussions for those with hearing impairments where only the condom was routinely named, and occasionally the pill. Some participants acknowledge the health benefits of contraception, whilst others believed that there were health risks such as sterility attached to contraceptive use.

Amongst the 23 interview respondents who had had sex, 15 (65%) who had had sex reported ever use of a contraceptive method- of which only 2 were female and both were married -and 8 reported (35%) never use of contraception.

The focus group discussions and interviews revealed that condoms were the only method consistently cited as used by all groups; all reports of method use refer to condoms except for two isolated cases where married women reported using the pill and injectable. Service providers also reported that short-term methods were the most frequently used by young people, especially condoms but also the pill, injectable and emergency contraception. One provider said the discretionary nature of the contraceptive method was an important determining factor. Trends of men being responsible for purchasing condoms emerged during the interviews with YPWD. Whilst some respondents reported always using a condom during sex, others –who had had sex-reported never having used one:

"I am a man; I am not afraid to go buy condoms, no matter the place.... I always protect myself before having sex" (*male, 19, hearing impairment*)

"I have never bought a product related to sex, but I was once shown a condom" (*male, 20, visual impairment who has had multiple sexual partners*)

Gender norms

Several factors emerged as influential to YPWD's perception or attitude to sex before marriage and the use of contraceptives. Whilst several men and women claimed their religion was against contraceptives and that unmarried women (or married women in some cases) should not use them, during focus group discussions and interviews **young women more frequently than men demonstrated conservative and judgemental attitudes related to sex and contraceptive use outside of marriage**, using strong language as demonstrated in the extracts:

"For me, no single girl **has the right** to have sexual relations. It should be done only after marriage" (*female, 19, visual impairment*)

"I am a person who respects herself a lot; for that reason, I don't mess around with men" (*female, 24, physical impairment*)

"A **good person** shouldn't have sexual relations before marriage" (*female, 22, physical impairment*)

Other perceptions of how women with disabilities in particular are seen in society were evoked, implying that women with a disability who have sex or children outside of marriage risk being further judged about their sexual behaviour:

"Given the perception that society has of people living with a disability, I avoid falling pregnant outside of marriage" (*female, 22, visual impairment*)

"It's rare for young women with disabilities to have sexual relations before marriage...to avoid negative judgement by the society in which we live" (*female, 24, visual impairment*)

Male participants were more comfortable talking about their sexual experiences, including sex outside of marriage. Negative attitudes to women having sex and using contraception outside of marriage were echoed during two focus group discussions but were overall less frequently pronounced, but some men did focus more on social norms related to how married women should not use contraceptives:

"**I do not approve** of married women using family planning" (*male, focus group*)

"When you are with your wife, **you do not need to use family planning**" (*male, focus group*)

The role of different family members according to their gender in supporting YPWD revealed some trends; female respondents largely reported female family members (especially sisters but also mothers and aunts) as sources of advice, whilst for male respondents there were isolated cases of male family members (brothers, followed by cousins, uncles and fathers) but more of a dependency on friends.

Source of advice and information

YPWD were asked about who they confided in or turned to for advice regarding puberty, relationships, and their SRH. Although a significant number confided in no one at the onset of puberty, others confided in family members and friends about the changes they were experiencing. Friends were the main confidants for relationship advice, for both male and female respondents and across all disability groups, followed by family members. Very few respondents reported confiding in anyone for SRH advice; those that did also reported family members and friends as their confidants. Fathers were very rarely mentioned as confidants by any male respondents, but brothers, cousins and uncles were occasionally cited.

When YPWD were asked if there was anyone that they would not confide in about relationships or to seek advice from, nearly all respondents said their parents or one of their parents. This was the case for both male and female respondents, but for different reasons. For male respondents, the reasons given were largely related to the subject of sex and relationships being taboo and they were too ashamed to discuss it:

"[I avoid] my parent. I was embarrassed to talk about these sorts of topics with them" (male, 23, hearing impairment)

For female respondents, topics related to sex were avoided due mainly to fear of their parents' reactions, followed by taboo about discussing such topics:

"[I avoid my parent] for fear that they will shout at me" (female, 22, visual impairment)

"In my family, we never talk about questions related to sexuality" (female, 20, hearing impairment)

Across the disability groups and both sexes, the highest proportion of YPWD who mentioned they would avoid confiding in their parents or others, were those with hearing impairments.

YPWD were asked if they had any other sources of advice or information, aside from their confidants, for accessing SRH advice and information. The majority answered that they had no other sources, or had a total absence of knowledge of services existing, and that this was a major issue.

"The main problem remains the lack of information regarding the existence of such structures" (male, 24, visual impairment)

“I didn’t know there existed SRH facilities in Senegal” (*female, 24, physical impairment*)

“

I don’t know of a place where can i get advice

”

(*female, 19, hearing impairment, rape victim*)

The few that did have other sources cited the radio for male respondents with visual impairments, and television debates and talk-shows by female focus group participants with physical impairments. On two occasions schools were a source of information; a talk on HIV/AIDS, and a teacher who provided information and referral to a hospital.

Whilst exact figures were not shared, information providers reported a high volume of young people accessing information, advice and support about SRH. To a lesser extent, or sometimes an unknown extent (for information providers using SMS or phones where the disability status of the caller may not be revealed), to YPWD. Information channels in place amongst the information providers interviewed include SMS, phone lines, social media (e.g. Facebook), drop in centres, peer education and community-based IEC.

Support Networks

Participants across all disability groups and sexes demonstrated a need to be accompanied by a family member or friend to access health services. Focus group discussions revealed that participants with hearing and physical impairments always needed accompaniment to access as services; those with hearing impairments reported always being accompanied by a family member, and those with physical impairments often had to ask a friend or family member to accompany them. Two interesting findings from focus group discussions with men with hearing impairments highlighted the dependency on their family members, due to the communication barriers they experience. In one group, two participants said they were sexually active but had no one to talk to about it except for to their family. In another case, one male participant depends on his mother:

“

The fact of not being able to communicate with others causes us enormous problems. I am obliged to be accompanied by my mother

”

(*male, 24, hearing impairment*)

Access to SRH Information and Services

YPWD were asked a range of questions about access to SRH services: if they access services, where they access them, what factors influence their choice, where they would prefer to access services, where they would avoid accessing services, what barriers they face to services, and how they would suggest overcoming such barriers.

Accessing SRH services

The majority of YPWD in focus group discussions and interviews reported to have never used an SRH service, and frequently reported not knowing where they could access such services. Across all disabilities and sexes, YPWD expressed a severe lack of knowledge of where to access such services:

“I never thought of going to see a health professional for advice related to sex ... because to me it's something taboo I have never avoided a health facility because I do not know them. I have no information about these facilities” (*male, 23, physical impairment*)

Only 9 interview respondents (out of 50) reported having ever accessed a SRH service, of which 5 had had sex. Those who had not had sex but had used a SRH service did so for gynaecological reasons (related to menstruation or gynaecological infections).

“I noticed that young people with visual impairments have no information on SRH”
(*male data collector, journal extract*)

Service providers reported numerous young people accessing SRH services at their facilities, but to a much lesser extent YPWD. Most referred to having provided services to some YPWD, but the frequency of YPWD was not reported.

Where young people with disabilities are accessing SRH services

The 9 respondents who did access information and/or services reported using their local public health centre or hospital, mainly due to their proximity to their house, or the public sector youth information centres called “Centre Ado”. Others reported private sector services such as Info Ado (a phone line and SMS service operated by the non-governmental organisation- OneWorld), ASBEF (the local IPPF affiliate), the Association of Women with Disabilities, or private pharmacies. Community health workers who primarily focus on women’s health -called Badienou Gokh-were cited during several focus group discussions with women with physical impairments and in one for women with visual impairments.

Where young people with disabilities are accessing SRH services

Three main influential factors identified by YPWD as affecting where they would choose accessing SRH services were;



confidentiality



anonymity



proximity

Pharmacies were often cited due to their proximity, quality and confidentiality, whilst local public hospitals noted for their proximity, and Info Ado for its anonymity and convenience as it does not require travel (as by phone or SMS). Fear of being recognised accessing a SRH service was apparent amongst several respondents, and this risk was often linked to the public sector;

“[I would avoid] the public sector because there are too many people and you can meet someone who you know” (*female, 22, physical impairment*)

The majority of interview respondents did not state places they would avoid seeking SRH services, but those that did respond reported that poor quality of products and services received from health providers, as well as the distance to access services, were the main reasons for avoidance. Boutiques were named as places to avoid due to the perceived poor quality of products sold, whilst some health centres were named as they were rumoured to provide poor quality services or care.

All providers confirmed that they believed confidentiality was the most important criterion for a young person selecting a service, and perceived that provider attitudes and cost of services were also key factors. Information and service providers spoke of the importance of not judging young people, despite socio-cultural norms that prevail about sex outside of marriage, and providing them with confidential and safe spaces to access SRH information and services. Free information was made available to young people via toll-free phone and SMS numbers, and free or subsidised services were often offered to young people, to help young people overcome the financial barrier.

Preferred place to access SRH services

During focus group discussions, participants were asked whether they would prefer to access SRH services through the public or private sector. Responses were divided across sexes and disability groups, but some clear trends emerged; private sector providers were largely considered of higher quality in terms of treatment and client care than public sector providers. Public sector providers were preferred by others but the main reason given was because it was more affordable than the private sector, or in seldom cases healthcare costs were subsidised.

The interviewees were asked more generally where they would prefer to access SRH services. Several stated pharmacies due the reasons above-mentioned, public health centres, or private providers.

Barriers to accessing SRH services

Focus group discussions revealed recurrent barriers to accessing SRH services. Across both sexes and all disabilities, **the two main barriers identified were financial barriers to services and provider attitudes. Other important barriers cited were parents' attitudes, physical accessibility, and communication barriers (for those with hearing impairments).** To a lesser extent marriage status, religion and lack of information about where to access SRH services were mentioned. The interviews reiterated these barriers. For those with hearing impairments, the communication barrier was particularly pronounced, with dependency on family members to accompany them.

Male and female participants with visual impairments insisted on the financial barriers not only to access services, but to purchase any medication. Female respondents with visual impairments highlighted the issue of discrimination by health providers, using language to express degrading feelings related to their experiences such as "they make you feel your disability", "they marginalise us" and "they neglect you because of your disability". Male respondents with visual impairments reported more internal barriers they faced, such as having hang-ups ("complex") about seeking SRH services:

"I have this complex to go to a health facility or see a professional in this field" (male, 23, visual impairment)

For respondents with physical impairments, the barriers identified were in the same vein; financial barriers (including cost for transport), shame/embarrassment, but also for this group in particular physical access to health centres was highlighted. This could relate to stairs in health centres that impede them from having easy access, or having to be accompanied by someone to facilitate access.

Providers also reported that the cost of SRH services was a major barrier faced by young people. One provider explained that students with whom they work get a monthly student allowance of between 18 000 F and 36 000 F (€27-€55) (to cover food, transport, books etc.) leaving them with a negligible purchasing power to buy SRH services. Another provider highlighted that young people do not have a regular source of income and cannot ask their parents for money to spend on a SRH service, due to taboo.

“There was a youth who confessed that he always shared condoms with his friends, to satisfy their needs. Because they didn’t have the means to each buy condoms. See what that does...”
(*information provider, Dakar*)

Pricing strategies for SRH services quoted from service providers during Phase 2 varied – three providers charge 1000 F (€1.5) for a consultation, and two have schemes in place to offer free services. One provider in Kaolack reported providing free services to YPWD in certain cases. One information provider argued that cost is not the major barrier (as many private providers offer services at subsidised prices) but that the fear of judgement from providers is the main determining factor for whether a young person will seek SRH information or services.

Provider attitudes to contraceptive use by young people

When information and service providers were asked which contraceptive methods they thought were the most appropriate for young people, and YPWD, most providers reported that clients should make an informed choice of their preferred contraceptive.

“All methods are appropriate; it depends on the person’s choice. Today, even if the socio-religious context does not approve of the use [of family planning] before marriage, we offer these services. We do not discriminate against any young person” (*service provider, Dakar*)

Service providers reported that young people had a tendency to choose short term contraceptive methods, such as condoms, pills, the injectable and emergency contraception. Two information providers however claimed that they primarily encourage young people to abstain from sex, or to use condoms and be faithful to their partner:

“People in all our programmes would still advocate for abstinence; failing that the use of condoms and faithfulness permits you to already avoid...But personally, I would say to abstain; I would say use condoms because it is not just pregnancy that you have to avoid”
(*information provider, Dakar*)

Suggested ways to overcome barriers to SRH services

YPWD were asked for their suggestions about how they think these barriers to access could be overcome. Suggestions were frequently about reducing financial barriers to services, but other more specific ways to overcome structural barriers were also suggested:

- **Financial accessibility:** Provide services at a reduced cost or free, including access to medical cards that entitle people with disabilities to free services;
- **Providers:** have young female providers to provide SRH services for young women, and have health providers who can communicate with people with hearing impairments;
- **Accessibility:** improve accessibility to health centres for people with disabilities (introduce ramps for physical impairments, audio information...), create health centres or have specialist doctors for people with disabilities;
- **Information:** provide information on where services can be accessed and what contraceptive methods are suitable for people with disabilities;
- **Parents:** raise awareness amongst parents on SRH of YPWD.

Discussion

This study provides initial insights into the experiences, attitudes and factors influencing the sexual and reproductive health-seeking behaviour of YPWD. Whilst the study does not claim to be representative of these groups, some clear trends were identified and notable findings discovered.

A significant proportion of YPWD are in relationships or have already had sexual experiences, and some are using SRH services in the private sector, contradicting the misconception that people with disabilities are not sexually active. Sexual experience was not always linked to marriage, with a relatively low number of YPWD married but a greater number of YPWD reporting having had sex than the number who were married. Nevertheless, knowledge about contraceptive methods was relatively low and largely limited to condoms. A worrying number of YPWD had never used contraceptive before. Unfortunately, this indicator was limited to ever or never use, as opposed to identifying the systematic use of contraception at every sex. At a minimum, if 35% of YPWD have never used contraception but have had sex once or multiple times, and **a very low proportion of YPWD have accessed a SRH service**, there exists a significant risk of unintended pregnancies and STI transmission.

To understand why YPWD were accessing SRH services or not, their attitudes about certain key SRH aspects were explored. Conservative attitudes to sex and contraceptive use outside of marriage for women resonated amongst several participants in group and individual settings, grounded in gender norms. Many female participants expressed disapproval of sex outside of marriage, perhaps reiterating the gender norms that are expected of young women to uphold in Senegalese society. These norms were expressed during focus group discussions and could have influenced other female participants to conform and therefore not disclose their true sexual experiences. Men expressed similar opinions, but less frequently, but in some cases were opposed to contraceptive use for married women, potentially compounding the social and gender norms of married women as faithful procreators. The increased comfort of men to talk about their sexual experiences may also reflect gender norms of acceptability for men to discuss and engage in sex, including outside of marriage.

Private providers believed that ensuring a confidential and welcoming environment for young people, and reducing the cost of SRH services, were key factors that influence why young people are accessing their services. However, there remains a disconnect between Phase 1 and Phase 2, as despite these “youth-friendly” services in place for young people in the private sector that are reaching many young people, YPWD reported negligible use of them. It is possible that the existing services are not sufficiently targeted at, or inclusive of, YPWD. YPWD expressed desire to seek services via the private sector but their health-seeking behaviour may consist of not seeking these services today, perhaps due to perceived financial barriers or lack of knowledge that NGOs at subsidised costs exist. Out of a small purposive sample of providers, two emerged as providing confusing messages to young people by encouraging abstinence first, followed by condoms and faithfulness. This surprising finding, amongst organisations who are influential in providing

information to many young people, are providing biased information on contraceptive services and reproductive choices. This influential and confusing information to young people, can lead to them not seeking a contraceptive method, increasing their exposure to unplanned pregnancies and STIs. This highlights the need for any information or service provider to be trained in youth friendly services and for a clear definition of what this means to be communicated, whereby informed client choice of their preferred method of contraception is at its core.

Sexual violence emerged as new theme during the data collection. Nearly 20% of young women interviewed reported being raped, mainly by men within their family networks. Females with hearing impairments represented the majority of these cases (4 out of 5), and a worryingly high proportion of cases (57%) of all women with hearing impairments reported a rape. Only one respondent (with physical impairment) reported seeking medical attention following a rape, with all other cases reporting no medical, legal or social support sought. The vulnerability of women to rape, with a particular attention to those with hearing impairments, must be further explored to better understand the prevalence of rape, the reasons for not seeking support or care following the assault, and how medical, social and legal professionals can respond to their needs. The role of support networks for people with disabilities could be instrumental here in providing support to rape victims, especially for women with hearing impairments who have significant communication barriers to access support services. Providers are often confronted with cases of rape, in which most cases they have to refer on to social services to manage as they do not have the capacity. If private providers are considered as safe places for young people to come to confide about cases of rape, the relative role of these providers in accompanying young people through the process should be further explored.

YPWD face a double-burden in accessing SRH services; barriers associated to their age and barriers related to their disability. It could be argued that young women with disabilities face a triple burden, due to the social norms and expectations of women in Senegalese society in relation to preserving their virginity until marriage. Barriers identified that affect YPWD's access to SRH services include financial barriers, provider attitudes, religion and lack of access to information about where they can access SRH services. Barriers identified related to disability include provider attitudes (in relation to managing and understanding disability) and capacity (e.g. ability to communicate with those with hearing impairments), financial barriers (due to increased risk of poverty amongst people with disabilities), lack of access to information about SRH services (due to absence of disability-friendly information e.g. in braille, IEC of SRH services to different disability groups etc.), and physical accessibility to health centres. The frequent mention of financial barriers, and the negligible mention of the *carte d'égalité des chances*, highlights that this card has not yet been made available or had an impact on this population's access to health services. The absence of information and the negligible use of SRH services by YPWD who were sexually active and/or in relationships, leads to the conclusion that current youth-friendly interventions are not reaching these groups or responding adequately to their unmet needs.

YPWD have demonstrated a need for increased social support to access health services, with many unable to access services alone. This disempowers their ability to access information and services confidentially and anonymously, as they need to be accompanied by a friend or family member, and this could be a major barrier explaining their health-seeking behaviour. In some cases, parents were described as confidants, but in many other cases YPWD said they would avoid their parents to discuss SRH or relationships. If this is the case, the role of parents and other people in their support networks, needs to be considered carefully. They could help provide a more enabling environment to discuss SRH with YPWD, but could equally be a barrier themselves and must be overcome.

YPWD want to access SRH information and services that are confidential, in places where their identity can go unnoticed, and where they do not have to travel far to access them. **To enable access, YPWD would also need information about where they can access services, services would need to be free or at a subsidised cost, and providers would be able to effectively communicate with them.** Overall, it can be concluded that the public sector plays an important role for several YPWD due to the lower costs of services, but is equally a deterrent for others who fear the lack of confidentiality and anonymity of the public sector. The private sector was a preferred source for services but only if services are at an affordable price. Service and information providers claim to provide services that are confidential, anonymous, and at an affordable price, yet hardly any YPWD mentioned using their services. This may be because the private providers do not have strategies in place that specifically target YPWD, but address young people more broadly, and therefore do not reach YPWD in terms of information and services. In the case of the one service provider that does have a disability-specific strategy in place, this provider was only identified by 2 participants in Phase 1, so the impact of this strategy should be evaluated. This study reveals that **existing interventions are not reaching the large majority of YPWD, and that new strategies are required to meet their unmet needs.**

Private providers selected in Phase 2 are not representative of the private sector- following a low rate of identification of private providers by YPWD in Phase 1, they were purposively targeted as they were known as key players in the provision of SRH information and services to young people. Unfortunately, due to study limitations, a random sample of private providers, including more clinics and pharmacies, was not possible. What was deduced from this sample, was that numerous interventions are in place to respond to the needs of young people and are proving successful to date- whether it be confidential phone lines or youth-specific services at clinics. These providers highlight that there is a need for such services, that young people are sexually active and in need of advice and services, but also demonstrate an understanding of how to deliver services to young people (confidential, non-judgemental, appropriate opening times, anonymity etc.). When compared to the perceptions that YPWD have of services via the public sector, where confidentiality and anonymity are limited, the private sector could provide them with the services they need. YPWD are not excluded from these interventions and their inclusive approach to any young person is perhaps a positive approach to not discriminate YPWD and treat them as a separate group. It is important however to understand that YPWD have distinct SRH needs, and that the mechanisms in place for providing information and services may not be accessible for them.



Information providers refer young people to local public and private service providers known to work with young people. What is not guaranteed, is once the young person is referred, is their assurance that a quality, youth and disability friendly will be received? Youth friendly information can be provided but unless referrals are made to quality-assured or accredited youth friendly clinics, a young person could be deprived of the service they need. Every step in the cycle of accessing SRH services must be considered.

Disaggregating data from Phase 1 across sex and disability group proved beneficial and helped identify different attitudes and experiences, from attitudes to sex and contraception, sexual violence, and barriers to SRH services. Their needs are distinct and the way to respond to them must therefore also be.

Recommendations

Study findings revealed a range of enablers and barriers for YPWD to access appropriate SRH services. Below are some suggested programmatic and policy recommendations to increase access to such services.

- **Increase access to information:** information in an accessible format must be made available to ensure equal access to SRH information for YPWD, as well as effective ways to make known to YPWD where they can access such information. This could include IEC materials in braille or audio formats, disability-specific IEC materials, adaptation of call centre and SMS services to respond to those with visual and hearing impairments, or the use of qualified interpreters for the provision and exchange of information. Involving support networks (friends, family, teachers etc.) could provide an additional means to reach YPWD with information on SRH, and they should be encouraged to discuss SRH more openly.
- **Replicate and expand SRH information services to YPWD:** information providers have the infrastructure in place to successfully provide information to young people- especially those working in SMS and phone lines- but must adapt it accordingly to ensure it is accessible to different disability needs. Expansion of these services would require further funding given the not-for-profit nature of the existing SMS and phone lines, but the success of them to date highlights the need for them to be replicated for YPWD.
- **Improve accessibility of SRH services:** to encourage access to SRH services, effective communication with providers is essential. Service providers would require youth and disability-friendly training. For people with hearing impairments, training health providers in sign language is an option or an alternative approach could be to train a group of interpreters who can cover catchment areas and provide neutral interpretation services to enable people with hearing impairments to communicate with health providers. The accessibility of health centres can be easily addressed through the investment of structural changes such as using ramps, locating consultation rooms on the ground floor etc. To increase confidentiality and overcome dependence on family members or friends to accompany YPWD to access services, a network of peer educators could be established to facilitate their access.
- **Train counsellors and providers in youth-friendly services:** information and service providers must be trained on youth-friendly approaches to guarantee that appropriate information is provided in the most effective manner to young people and YPWD. Standardised guidelines should be rolled out by any providers working with this population, and their services quality assured (see more below). For information providers who refer young people to other facilities to receive SRH services, it is important to quality-assure that youth-friendly services are providing throughout the cycle- from information provision all the way to the service received.

- **Improve referral linkages between information and service providers:** out of the sample interviewed, few linkages were identified between information and service providers. Information providers often refer young people to local public health centres or identified one of the service providers in Phase 2 as a referral point. Information providers should provide young people with a range of (quality-assured) service providers to be referred to, increasing collaborations with local public and private providers.
- **Strengthen gender-sensitivity:** gender differences emerged that should be considered for further research and in the design of interventions. How to reach young women and men with effective information and services will require a different approach, considering the social and gender norms identified in relation to sex and contraceptive use outside (and inside) of marriage. Peer-led interventions disaggregated by gender may enable gender norms to be more openly discussed, but further research into possible models is needed.
- **Investigate the burden of sexual violence:** further research is urgently needed amongst YPWD to better understand the burden of rape experienced (by disability and by sex) and to quickly develop or adapt response mechanisms accordingly. Any young person who experiences rape or sexual violence should have access to confidential health, social and judicial services. For people with visual or hearing impairments, communication must be facilitated to ensure they can access information and services. Information about such services must be easily available to YPWD and a comprehensive package of care provided.
- **Explore the role of private sector providers in accompanying rape cases:** the role of information and service providers in accompanying young people who have been raped should be further explored as these providers are the first port of call for some young people and a place of trust. Tracking of young people through the process would be useful to assess if referrals to social services lead to appropriate support to rape victims.
- **Increase data on YPWD:** to enable policy makers and stakeholders to determine or refine youth SRH policies and interventions, more data is needed on YPWD and their SRH needs. National data on the scope of different disabilities by age group is scarce and is an essential component of understanding the target population for any health intervention. This study provides initial insights into the attitudes, experiences and barriers for YPWD but has limitations as SRH is a broad topic and the depth of certain topics explored requires further research, such as sexual violence and frequency and reasons for contraceptive use. Public and private providers could disaggregate and collect data on the number of YPWD they provide services to, to inform future strategies.
- **Remove financial barriers to SRH services:** to enable use of SRH services, they must be free or at a subsidised cost to YPWD. If the *cartes d'égalité des chances* are made accessible to all YPWD, where services can be redeemed with the card and the quality of the service provided must also be considered – if the card does not enable them to access services that are youth and disability friendly, then uptake is likely to remain low. Other ways to overcome financial barriers could be the introduction of a national pricing policy for cost of services for young people in the public sector, or free/subsidised services through the private sector.

- **Overcome financial barriers through demand-side financing:** public-private partnerships should be explored to improve access to quality SRH services for YPWD. The *cartes d'égalité des chances* should be redeemable in the private sector, with a reimbursement mechanism in place where the government pays a fee to accredited youth-friendly private providers per service provided to a YPWD. Explore public-private partnerships or voucher schemes with the government to support the quality and financial sustainability of the private sector whilst at the same time allowing the private sector to fill the gap in the provision of SRH services.
- **Inclusion of YPWD in SRH policies for young people:** young people cannot be approached as a homogenous group, without taking into account the specific barriers encountered by some, including those living with a disability. National SRH policies have recognised young people as a priority group, but have not bridged these policies to upholding the commitments outlined in the CRPD. Involvement of YPWD in developing and piloting youth and disability-friendly policies and interventions is encouraged to ensure they are appropriate and effective. A group of YPWD could be trained as peer educators to provide information and support to other YPWD about accessing SRH services.

Limitations

Given the personal and sensitive nature of the questions asked during focus group discussions and interviews with YPWD, there may have been some biased answers or non-disclosure of true information by research participants. Using young people as data collectors will have hopefully overcome some of these fears to disclose information, but it must be considered that some topics may have been under-reported or embellished. Data collectors provided an invaluable rapport with participants, but their data collection capacity was limited in some cases and themes not fully explored. Due to the limited timescale and capacity of the research team, the study could not include other disabilities such as intellectual and mental disabilities, which would have been of interest to include and would be encouraged for future research. YPWD under the age of 18 were unfortunately also excluded from the study, limiting the insights from this important group. The low number of private providers identified during Phase 1 by YPWD meant that purposive sampling was applied to identify providers. Due to limited time and resources, as a result, the providers in the study were selected based on their experience of already working in SRH and with young people, providing an unrepresentative sample of the private sector. Phase 2 interviews were largely conducted in Dakar and Kaolack; unfortunately, providers in Thies did not participate. The study was not a national representation as study areas were limited to Dakar, Thies and Kaolack and did not permit access to information on other regions of the country.

Conclusions

This study confirms the need for SRH services amongst YPWD, and highlights challenging experiences of accessing services amongst YPWD and often total lack of information about their sexual health. This puts YPWD at increased risk of adverse sexual health outcomes such as STIs and unintended pregnancies which potentially compounds the stigmas faced by YPWD where young people face especially conservative norms. The study found that YPWD are potentially highly vulnerable to sexual violence, including abuse perpetrated by family members or friends, and do not use nor have access to support health, social care and legal support mechanisms to mitigate the risk of sexual abuse.

To have a wider impact on SRH indicators in Senegal, young people cannot be left behind. Strategies to reach young people should therefore not consider young people as a homogenous group, but should recognise them as having varying complex SRH needs that must be understood in order to be addressed.

YPWD face a double burden in accessing SRH services: related to their age and related to disability. These two burdens must be taken into consideration if health providers want to effectively reach this population. Efforts must be made to adapt SRH information and service provision in order to do so; whether it be translating health promotion materials into braille for a young person with a visual impairment, providing an interpreter for communication between someone with a hearing impairment and a health worker, or adding a ramp to a health centre so people with physical impairments can more easily access health centres. Provider training in youth and disability-friendly services is also a key component for enabling access and to date remains a major barrier. These adaptations need to be accompanied by the necessary resources (financial and human), but if the Government is to uphold its commitment to the CRPD and the Reproductive Health Law, then coordination of these efforts must be prioritised.

The *cartes d'égalité des chances* are a first step to overcoming the financial barriers to healthcare for people with disabilities- but these cards must be quickly made available to all YPWD -and must be part of a wider effort to make SRH services more appropriate and appealing to YPWD. The financial barriers represent one of the barriers, but unless provider attitudes and youth and disability-friendly services are also made available, then SRH services will remain under-used by YPWD. To increase the use of SRH services, these *cartes d'égalité des chances* could be used in a range of service delivery points, including the private sector, which has demonstrated the willingness and potential capacity to fill the gap. Including the private sector as a place to use the *cartes d'égalité des chances*, could enhance public-private partnerships, also allowing the Ministry of Health to have greater visibility over the provision practices and quality of the private sector, whilst enabling YPWD to access services at a provider of their choice. The private sector can help respond to the needs of YPWD. The sample interviewed in Phase 2 already have models in place for young people to access SRH information and services, and whilst they are not currently known to, or being widely used by, YPWD, they could be a basis from where interventions can be easily adapted to be inclusive for YPWD.



Further research into YPWD's SRH, unmet needs, innovative technologies and techniques to respond to the needs of YPWD, as well as their risk of rape and sexual violence, are urgent. This study provides insights into some of the issues faced by YPWD but merit more investigation and consequent responses. Near absence of other research on YPWD in Senegal highlights that this group remains misunderstood and neglected from health interventions.

The Ministry of Health and partners in the public and private sectors have committed to increasing access for young people to SRH information and services. There exists a significant need to strengthen not only the health system to respond to the SRH needs of YPWD, but also the social and legal support systems too. Current interventions do not exclude YPWD, but are not inclusive either. Policies must reflect the acute vulnerabilities which YPWD face, and their specific needs must be considered in future efforts in order to uphold the commitments to protecting the SRH rights of young people and those living with disabilities.

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