An analysis of the capacities of healthcare providers to offer quality sexual and reproductive healthcare to women and girls with disabilities in Kenya

This Ability Trust

About This Ability Trust

We are a women-led nonprofit organization whose mission is to advance the rights and inclusion of women and girls with disabilities in Kenya. We envision a society in which women and girls with disabilities live fully integrated lives socially, economically and politically, with their rights respected and upheld. Our business model focuses on using business principles of marketing and advertising to make the case for investing in women and girls with disabilities where we prioritize amplify the voices of women and girls with disabilities, build partnerships and facilitate dialogue and engagement with key stakeholders and policy makers, and create visibility for the rights of women and girls with disabilities. We work to increase access to sexual and reproductive health rights and economic empowerment for women and girls with disabilities across 8 counties (Kisumu, Kakamega, Uasin Gishu, Kajiado, Nairobi, Kilifi, Kwale and Mombasa).

Background

Access to health is a fundamental human right as outlined in Article 43 (1) of the Constitution of Kenya 2010 which states that: Every person has the right-to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; Despite this provision in the law, women and girls with disabilities in Kenya, still face numerous challenges in access to sexual and reproductive health. The myths and misconceptions attached to their sexuality often hinders them from acquiring quality sexual and reproductive health services, they are denied the right to express their sexuality through forced and arranged marriages, forced sterilization, forced and unsafe abortion as well as denial of sexual and reproductive health information and education which creates a gap in their health and increases the susceptibility of untreated sexual and reproductive health illnesses.

Women and girls with disabilities are turned away from accesing sexual and reproductive health. Their sexuality is often overlooked by healthcare providers who only consider their disability hence hindering them from expressing their sexuality. They are considered a low priority in terms of sexual and reproductive healthcare programming, and therefore may not be provided with accessible services, education and information when seeking these services.

This prejudice and negative attitude from healthcare providers creates barriers to accessing healthcare for women with disabilities and prevents them from accessing the right information on sexual and reproductive health, which puts their life and health at risk. Inaccessibility in healthcare facilities remains another challenge from lack of ramps, lack of support for alternative modes of communication, such as Sign Language, Braille, and easy-read and other adapted tools.

Based on our previous work[1], women with disabilities need increased equal access to access sexual reproductive health services, due to the fact that they experience less decision making power and autonomy to exercise and enjoy their sexualities. The combination of discrimination based on disability, gender,

[1] UNFPA Kenya. 2020. https://kenya.unfpa.org/en/news/healthcare-workers-trained-address-sexual-and-reproductive-health-needs-women-disabilities

sexual orientation and other intersecting forms of identities may compromise access to quality healthcare services.

The Needs Assessment Approach

Methodology

A needs assessment questionnaire was conducted to understand the views, experiences and challenges of healthcare providers handling the sexual reproductive health rights on women with disabilities in the workplace. The questionnaire was shared to the respondents online via Google Docs. The first questionnaire was applied to the first cohort of students from Kakamega and Kisumu had 15 questions. After the initial analysis with the first respondents, we noted a few gaps and added an additional 12 questions. The final questionnaire has 27 questions with 17 open ended questions and 10 closed questions. We applied the same questionnaire to 3 cohorts of healthcare providers from Kakamega, Uasin Gishu, Busia, Kisumu, Mombasa, Tana River, Kilifi, Kwale, Kajiado, Nairobi and Kiambu counties.

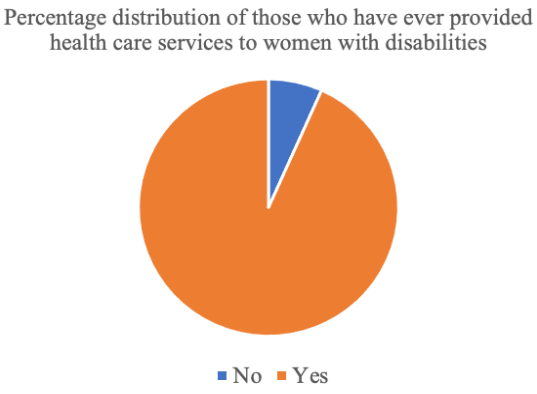
A total of 100 healthcare providers were sampled of which 81 participated. The healthcare providers participating facilities were selected from healthcare centers across the 8 counties we work in plus three neighboring counties: Tana River, Busia and Kiambu. 99% of them were from government health facilities. The cohorts were from Level 2, 3 and 4 health facilities. This assessment provided us with a comprehensive information on the gaps in the public health, cultural beliefs and practices when it comes to treating women with disabilities Sexual and Reproductive Health and Rights needs.

1. Findings of the Needs Assessment

1:1 Providers who have offered healthcare services to women with disabilities

93.3% of the respondents who filled out the survey provided healthcare services to women with disabilities at one time or another during their work as depicted below.

Figure 1: Distribution healthcare providers who have offered health care services to women with disabilities



1.2: How many types of disabilities are you aware of?
Awareness of the different types of disabilities is significantly low among the respondents with 51 of them stating knowledge of three or more disabilities reflecting very poor knowledge about the diversity of disabilities.

Table 1: Awareness of types of disabilities

Types of disabilities	**No. Of Healthcare Providers**
10	1
2	14
1	7
3	9
4	17
5	15
6	10
Did not answer	8
Total	**73**

1.3. Kindly mention the type of disabilities you mostly encounter when providing SRHR services?
This question was exploring their raw understanding of the different disabilities and how they name them. Physical disability was the most common type of disability known to the respondents at 38.8 % followed by mental*(sic)* disability at 20.8% and hearing impairments at 14.9%. Significantly, five other disabilities were each known by only 1% of the providers. The other disabilities known to the respondents at a shared 25.5%. These were blindness, loss of limbs, loss of hearing, cognitive disabilities, psychomotor impairments, hearing problems, partial/permanent disabilities, visual and emotional problems.

Table 2: Types of disabilities as described by the respondents

Types of disabilities[2]	**Frequency**
Physical disability	52
Mental	28
Hearing problems	20
Blindness, loss of limbs, loss of hearing	14
Visual	14
Cognitive psychomotor	2
Partial, permanent	2
Albinism	2
Did not answer	8
	73

[2] This language was provided by the healthcare providers, and is reported verbatim.

1.4 Experiences in handling women with disabilities

Slightly over half of the healthcare providers (51.8%) reported having had fair experiences when handling women with disabilities with another 29.7% reported "good" experiences and 18.3% had unpleasant experiences.

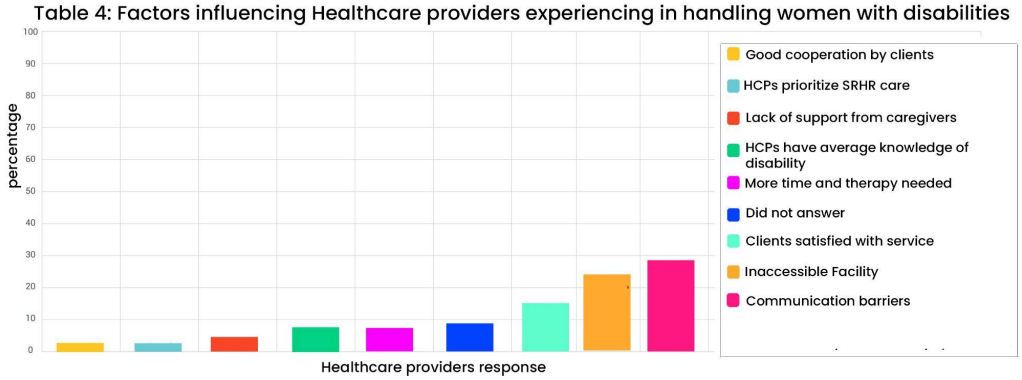
Table 3: Healthcare Providers' experiences when handling women with disabilities

	Frequency	Percent
Fair	42	51.8%
Good	24	29.7%
Unpleasant	15	18.5%
Total	81	100.0

1.5: Factors influencing Healthcare providers' experiencing of handling women with disabilities

The healthcare providers who cited 'good' experiences in handling women with disabilities pointed to the enablers of this experience being "good cooperation" from the patient and relatives as well as their own personal commitment to "just serve them and handle them diligently with empathy." However, the healthcare providers who had experienced less-than-positive experiences pointed to a range of personal, systemic and social causes that include communication challenges which often lead to misunderstanding as well as lack of infrastructure to handle women with disabilities. Some healthcare providers stated that, patients with certain disabilities, especially mental impairment(sic) , are not allowed to give informed consent compelling the healthcare providers to seek consent from a guardian or relative. This situation, according to one provider, "promotes coercion." A number of healthcare providers reported having "average disability awareness", lack of training to handle different cases of disability and the ability to communicate effectively with women with disabilities.

Table 4: Factors influencing Healthcare providers experiencing in handling women with disabilities



1.6. Do you experience any challenges while providing Sexual and Reproductive Health services to women with disabilities?

Table 5: Challenges of providing sexual and reproductive health services to women with disabilities

	Frequency	Percent
Yes	71	87.7%
No	10	12.3%
Total	81	100%

1.7 Kind of challenges experienced by Healthcare providers in offering sexual and reproductive health services to women with disabilities

Among the four cohorts of healthcare providers, majority of the respondents cited challenges in offering sexual reproductive health services to women with disabilities. These could be categorized as communication, attitudinal and physical barriers.

Lack of knowledge of Sign Language by the healthcare providers or the absence of Sign Language Interpreters in the facilities hindered how they communicated. One respondent further stated that when young girls seeking Sexual, Reproductive Health services were accompanied by parents and Sign Language Interpreters, they were shy to talk about it.

Language and communication barrier while offering services to intellectual and psychosocial disabled women is also a challenge as the healthcare providers don't know how to communicate with them. It also became difficult for the women with disabilities to open up if they were accompanied by someone else.

The respondents also said blind clients can't see the demonstrations being done during health education on types of family planning services, hence it was difficult to communicate.

Inaccessible facilities. There are challenges with mobility and positioning of clients with some forms of physical disability due to inadequate infrastructure such as, in the words of one provider, "insufficient services geared towards serving persons with disabilities such as wheelchairs.

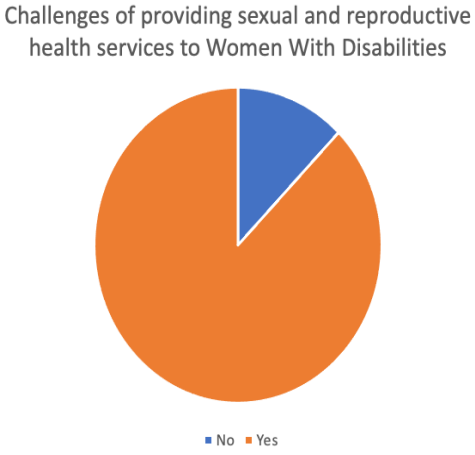
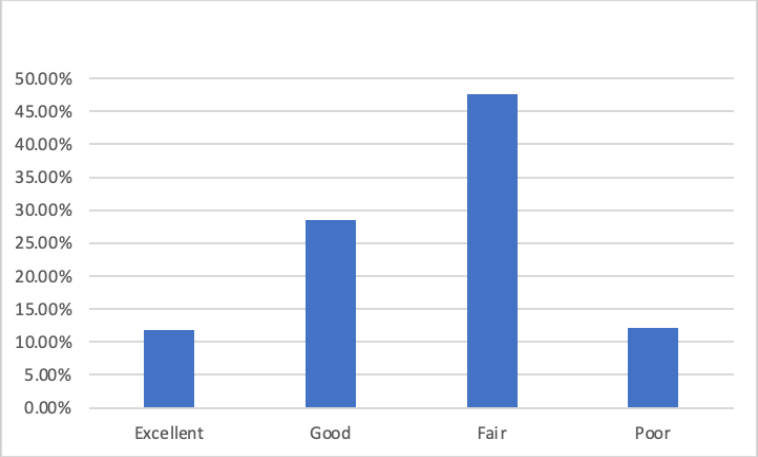


Figure 2: Challenges of providing sexual and reproductive health services to women with disabilities

1.8: Overall, how would you rate your facility in terms of providing SRHR services to women with disabilities?

Only a minority 11.8% of the healthcare providers perceived the facility they worked in as offering "excellent" services to women with disabilities. The other healthcare providers rated the services at their home facility as "fair" (46.7%), "good" (28.5%), and "poor" by 12.1%

Figure 3: Healthcare *providers" rating of facility SRHR services to women with disabilities*



1.9: Facility provision of comprehensive abortion care (CAC) to women with disabilities

A majority of the healthcare providers reported that their facilities always insisted that women with disabilities had to have a chaperone and their guardian for confidentiality, assistance and easy communication. The processes included explaining the procedure, helping the clients with physical disability to climb a couch, offering counseling, prophylactic treatment and health education. However, most healthcare providers reported that they did not offer comprehensive abortion care but instead provided post abortion care (PAC) "due to Kenyan law which has not approved". Moreover, not all healthcare providers are trained on management of patients with disabilities.

The respondents also pointed out that there was an increasing number of women with disabilities seeking services in facilities. In cases where services were provided one of the respondents stated, they offered family planning services and products to the clients post abortion. Their facility also offered referrals to emergency abortion treatment services. Treatment of incomplete and unsafe abortion and complications of spontaneous and induced abortion was also offered. A few also pointed that abortion services were not offered in their facilities. This is attributed to lack of skills and knowledge and also supplies in terms of equipment and drugs. In such cases the respondents refer the women to other facilities.

1.10: Provision of HIV testing to women with disabilities

Generally, the healthcare providers reported offering HIV testing services to women with disabilities by explaining the procedure through counseling, "allowing them to make informed choices". The services were offered through outpatient, antenatal care and delivery services. Services were given through provider initiated counseling and testing, written word, demonstration and referral to disability websites. The respondents also cited counseling to identify and respond to women's emotional and physical health needs. They provided of pre/post exposure prophylaxis (PEP/PREP) to HIV for clients who were raped by unknown person or persons whose HIV status is queried.

A few facilities have HIV-Trained Services (HTS) trained personnel to offer disability inclusive services. However, the healthcare providers reportedly did not offer special provisions to women with disabilities except for those who are Deaf. Services were provided on the same basis as non disabled people and as one provider asserted "pre and post test counseling is done shallowly" and in the same as for the general population although they "require "translators making the job take longer."

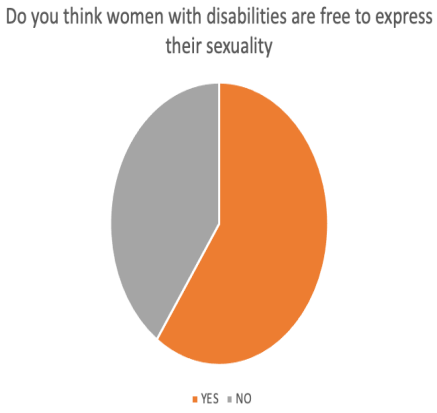
1.11 Availability of safe space for women with disabilities for their sexual and reproductive health rights needs

Only a minority of the healthcare providers reported working facilities that are giving priority to women with disabilities and creating safe spaces for them. A majority of facilities lack comprehensive visual information on walls for demonstration, for the clients. Few have an inclusive environment and consideration to patients with disability, a Gender Based Violence department to offer support and counseling services to the affected persons and healthcare providers trained on disability. One provider pointed out that the lack of safe spaces clearly indicates that clients with disabilities are not getting personalized care/services. A gap was noted in unavailability of separate counseling rooms that are private and enhance confidentiality. Facility managers have not offered clear guidelines on the safe space issue which is currently left to the caretakers. Most level 2 and 3 facilities make referrals to the sub county hospitals.

1.12 Facility-based provision of quality maternal and child health care services to women with disabilities

A minority of the healthcare providers worked in facilities that offered comprehensive antenatal care and child welfare clinics that understand the needs of women with disabilities and offered services as per need. These few facilities encouraged and educated all women with disabilities on the importance of quality maternal and child healthcare services; followed the laid down policies by Ministry of health (MOH) in provision of such services and worked with the Community Health Extension Workers (CHEWS) and Community Health workers (CHVs) for easy communication and assistance. The facilities gave the women with disabilities the first priority when offering services reducing waiting time. A few of the facilities had adjustable beds for testing on women who are physically disabled.

However, a majority of the healthcare facilities don't have inclusive equipment or accessible infrastructure.



1.13: Do you think women with disabilities are free to express their sexuality?

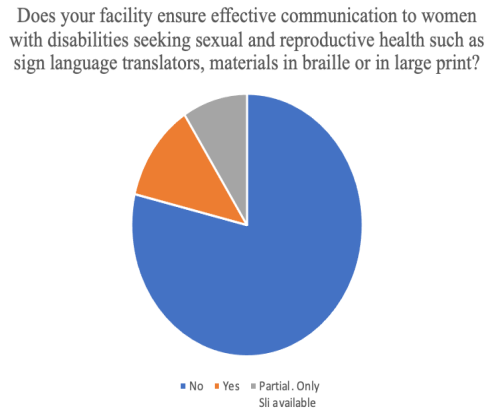
According to the respondents 59.72% believe that women with disabilities are free to express their sexuality. They pointed out that women with disabilities "are normal" and deserved their human rights. They believed as healthcare providers it's not their place to judge clients but to deliver services.

Gender discrimination and lack of privacy when seeking sexual and reproductive health services were highlighted as a factor hindering women with disabilities while expresing their sexualities. The lack of privacy is a barrier to express themselves freely, since most of them have to be accompanied by a relative, especially the Deaf, blind and those with intellectual disabilities..

Figure 4: Do you think women with disabilities are free to express their sexuality?

1.16 Counseling services offered by facilities to women with disabilities for access to family planning services

The respondents reported that their facilities had been providing counseling on the benefits of family planning to general clientele using WHO guidelines. However, the healthcare providers reported that there was a general assumption that women with disabilities might not comprehend hence any counseling was offered to those most of the time. In terms of effectiveness of communication to women with disabilities seeking sexual and reproductive health services, it varies from facility to facility and is dependent on the service provider and the caretaker. Only a negligible number of facilities have a Sign Language Interpreter available. Communication materials and equipment are generally lacking.



1.17 Does your facility ensure effective communication to women with disabilities seeking sexual and reproductive health such as Sign Language Interpreters, materials in Braille or in Large Print?

Majority of the facilities don't ensure effective communication for women with disabilities in terms of Braille or Sign Language.

*Figure 5: Does your facility ensure effective communication to women with disabilities seeking sexual and reproductive health such as sign language translators, materials in braille or in large print?**

1.19 Accessibility of infrastructure for persons with disabilities

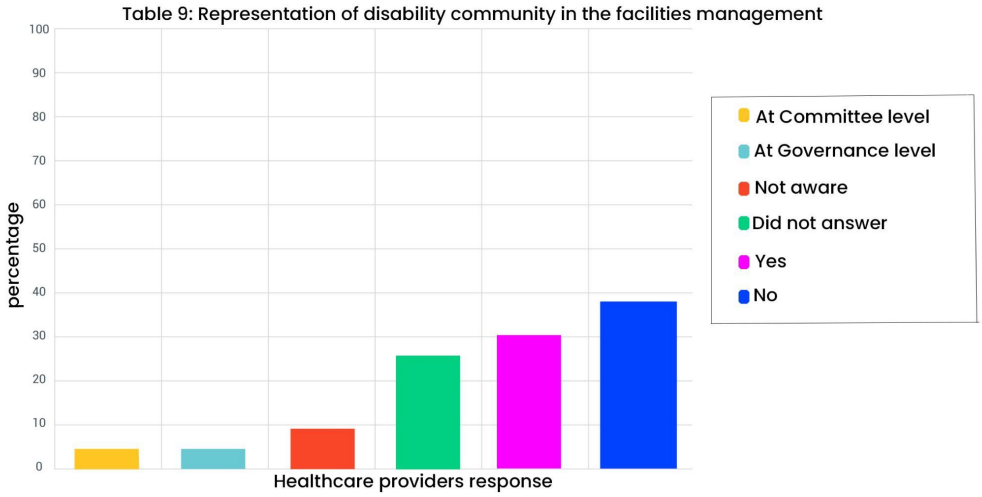
A majority of the facilities lack the necessary infrastructure for persons with disabilities such as ramps, accessible toilets, adjustable beds for women with physical disabilities.

Table 6: Accessibility of disability-friendly infrastructure

Level of access	Frequency	Percent
No	47	58.02%
Yes	21	25.90%
Ramps	7	8.7%
Adjustable beds	6	7.4%
Total	81	100.0

1.20 Does the management of your facility include representation from the disability community?

A majority of the facilities lack the representation of the disability community, though there is an important percentage of facilities that have representation. Also there are facilities that have representation through the civil society committees.



Conclusions:
The maternal mortality ratio, the number of women dying of pregnancy-related causes, stands at 488 deaths per 100,000 live births. This ranks Kenya among the 10 most dangerous countries for a woman to give birth in the world[3]. In terms of maternal healthcare there is almost a total lack of accessible service provision for women with disabilities. Is it critical to ask how many women with disabilities are dying while giving birth. For a previous study we tried to find the specific maternal mortality rates for women with disabilities in the country and there is no specific data, which just shows us women with disabilities invisibility for the Government.

15% of our respondents had "unpleasant" experiences handling women with disabilities cases, in most of the cases the reason was their own lack of skills. We could also presume this lack of skills impacts directly on their clients and how they feel when they go for health care in the public services. It is important to highlight the challenges that become more when it is about SRH services, especially in terms of lack of accessible infrastructure, language barriers and lack of privacy and respect of the clients intimacy specially when they need a guard or an interpreter.

Based on the answers provided, it is critical to create awareness on the disability types and how to name each disability as well. We found sometimes the stigma starts with the language. It is critical to name the types of disabilities as they are known. When we use incorrect language, it presents a limitation in providing appropriate services. Correctly identifying disability provides an opportunity to understand and create tailored solutions that are need based and responsive.

On the other hand, it is also important to highlight the stigma reflected in some of their answers, for example when they say, "women with disabilities are normal, like other people". The way to understand "normality" is loaded with bias. Additionally, the framing of disability from a medical and impairment lens, referring to "mental, psychomotor disabilities" presents a challenge to perceiving women with disabilities as full and complete human beings with inherent rights. The way they use the language also shows us the lack of understanding of disability rights.

One of the biggest barriers that women with disabilities face when they looking for sexual and reproductive health services and information or gender based violence care is the lack of confidentiality. This prevents women with disabilities from denouncing gender based violence, especially because at times the perpetrator may be with them during consultation. Healthcare providers are aware that they are not offering safe spaces but they don't have the capacity to provide a safe environment for their clients with disabilities.

It is important to say that the healthcare providers are conscious of the needs they have in terms of providing services to women with disabilities, this shows us they are open and receptive to learning and sometimes to change their mindsets. We believe one of ways to improve the sexual reproductive health rights of women with disabilities is educating the community and breaking the cultural stigma among women with disabilities. There is a need to enhance the capacity of healthcare providers in offering services to women

[3] https://kenya.unfpa.org/en/topics/maternal-health-and-hiv

with disabilities and to promote their attendance to the facilities including opportunities for additional training presented by offering community outreach and service provider partnership for prevention of unwanted pregnancies and unsafe abortion.

Finally, the willingness of healthcare providers to be part of our trainings on the sexual and reproductive health and rights of women with disabilities. All the respondents became part of the Healthcare Providers Course based on their willingness to improve their service provision. It shows us the importance of providing relevant training and content to continuously improve their skills.

Recommendations:
Cultural barriers are the biggest barriers when working to ensure equity an ones when it is about sexual and reproductive health services access for women with disabilities, it is important to keep creating spaces to educate the community from a gender and human rights standpoint. Sometimes it is not so difficult to create the bridges and solutions to provide quality services for women with disabilities, but for doing that the first step must be breaking the cultural stigma.

Based on this report and on Hesabika Annual report 2021[4], it is critical to standardize disabilities categories from a human rights standpoint. The language standardization would help the health facilities to collect curated data on women with disabilities and also will ensure the healthcare providers will have a better understanding on how to provide services to the diversity of women with disabilities.

The respondents pointed out that there was an increasing number of female clients with disability seeking services in facilities at which they worked which points to the need to enhance the capacity of healthcare providers in providing services to women with disabilities. It is mandatory for them to mainstream disability rights to provide better healthcare services, however they noted their own challenges to provide quality healthcare services for women with disabilities and proposed some possible solutions. They need more skills on disabilities rights with enphasis on the sexual and reproductive rights of women with disabilities.

For healthcare providers, the first step is to be able to provide accessible infrastructure to their clients, which includes improving facility infrastructure to include ramps, accessible toilets, accessible gynecological beds, among others. Another priority was to have more specific trainings on the sexual and reproductive health and rights of women with disabilities. Another important suggestion is to sensitize the community on the sexual and reproductive health and rights of women with disabilities.

Additional recommendations from the healthcare providers included the need for periodical training. The importance of having basic training on inclusive communications skills to make their services more accessible. The Ministry of Health and the Schools of Medicine should provide skills and build capacities on the sexual and reproductive health rights of women with disabilities. It is critical for them to have this course as part of the Continuous Professional Development (CDP) with the Ministry of Health.

[4] https://this-ability.org/wp-content/uploads/2022/07/Hesabika-Final-Report_final.pdf

The importance of advocacy with the Government was highlighted to support more investments on accessible and inclusive healthcare services. To support this, they proposed additional training on inclusive policies development and implementation. Integrating disability into pre-service training for all service staff as a majority of the healthcare providers have not received any training on disability.

It is important to provide this training for all the staff members including administrative personnel, since the inclusion and accessibility must start on the facility reception. To further strengthen the training, the healthcare providers believe it is also important to have mentorship sessions with other healthcare providers, to learn from them and share experiences. They also would like to work more closely with disability rights organizations.

Finally, as a result of this process, we designed our Healthcare Providers course to provide an introduction to the sexual and reproductive health rights of women and girls with disabilities. We have trained over 100 healthcare providers. This course could be strengthened and continue to serve as an induction to the Ministry of Health personnel and medical students. All the trained healthcare providers had the opportunity to have safe spaces of discussion with women with disabilities, now they are part of our referral services through Mama Siri toll free service, which exists as a safe space and bridge between women with disabilities and healthcare providers.