Citizen ADVANCEMENT INITIATIVE

AMERICAN JEWISH WORLD SERVICE

SRHR AND DISABILITY

Assessing The Level of Awareness, Experiences of Adolescents Girls With Disability (AGWD) On Sexual Reproductive Health And Rights (SRHR); And The Accessibility Of Informative Data On AGWD SRHR In Kisumu County.

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Acronyms and Abbreviations

AGWD:	Adolescent girls with disability
AGYW:	Adolescent girls and Young Women
AIDS:	Acquired Immune Deficiency Syndrome
ALHIV:	Adolescents Living with HIV
ANC:	Antenatal care
ARV:	Anti-Retroviral
ART:	Anti-Retroviral Therapy
ASRHR:	Adolescents Sexual Reproductive Health and Rights
CAI:	Citizens Advancement Initiative
CHVs:	Community Health Volunteers
CSE:	Comprehensive Sexuality Education
Co-I:	Co-Investigator
DHIS2:	District Health Information System
GDPR:	General Data Protection Regulation
GBV:	Gender Based Violence
HMIS:	Health Management Information System
HPV:	Human Papilloma Virus
HIV-	Human Immunodeficiency Virus
KHMIS:	Kenya Health Management Information System
KII-	Key Informant Interviews
KNCHR:	Kenya National Commission on Human Rights
LHIV:	Living with HIV
MCH:	Maternal and Child Health
MoH:	Ministry of Health
MTDP:	Medium-Term Development Plan
NACOSTI:	National Commission for Science, Technology, and Innovation
NASCOP:	National AIDS Control Program
NCPD:	National Council for Population and Development
PI:	Primary Investigator
PAC:	Post Abortion Care
PBF:	Pregnant and Breastfeeding
PMTCT-	Prevention of Mother to Child Transmission of HIV
PNC-	Postnatal Care
PWD -	Persons with Disabilities
SDGs -	Sustainable Development Goals
SRH:	Sexual and Reproductive Health
SRHR:	Sexual and reproductive health, and rights
STIs:	Sexually Transmitted Infections
VACs:	Violence against children survey
WHO:	World Health Organization

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Executive Summary

OVERVIEW

This report assesses the awareness, experiences of Adolescent Girls with Disability (AGWDs) on Sexual Reproductive Health and Rights; and the accessibility of information and data on AGWDs SRHR in Kisumu County. This research investigated the social barriers AGWDs face in accessing Sexual and Reproductive Health and Rights (SRHR) information and services in rural and urban settings of Kisumu County.

The purpose of the research was to assess awareness and experiences of AGWDs on SRHR and identify and discuss any barriers. A better understanding of these barriers will inform the design of inclusive SRHR programming, promoting the right to sexual and reproductive health for all, enhance inclusivity and advance the SRHR of AGWDs by using research data for advocacy.

STUDY DESIGN AND DATA COLLECTION

This research mainly applied qualitative data collection to address the study's objectives. The data was collected using three methods i.e., Literature /desk review, Key informant interviews (KIIs) and In-depth Interviews (IDIs). A total of 42 people were interviewed; for the In-Depth Interviews a total of 24 girls were interviewed (15 AGWDS in schools & 9 Adolescent mothers). For the Key informant interviews; 6 Health Care Workers, 3 Human Rights Defenders, 2 Sub-County HIV & STI Coordinators, 2 Sub-County Reproductive Health Coordinators, 2 Youth Champions, 1 Persons with Disability Champion and 2 implementing partners within Kisumu County.

The research applied a thematic content analysis, combining deductive and inductive approaches that led to the organization of findings in five main themes: Key experiences and perceptions of AGWDs, Inclusivity, isolation, and communication challenges, Awareness on SRHR among adolescent girls with disabilities (AGWD), Access to relevant SRHR information, Access, and utilization of SRHR services by AGWDs, Future perspectives of AGWDs.

Key Findings

To examine the barriers that limit AGWDs to get SRHR awareness and accessibility to SRHR information and services in Kisumu County, the analysis and discussion of the findings focused on aspects including the role of the key duty bearers, socially imposed barriers, the individual perceptions of AGWDs, and enabling practices that affect the social wellbeing of AGWDs.

- The gathered information in this research reveals the prevalence levels of isolation and abuse, including gender-based violence (GBV) amongst AGWDs.
- High levels of dependency on relatives through lack of accessible communication opportunities and self-selected social networks outside of the close family system.
- Lack of all-inclusive services at all service delivery points including health facilities without social amenities friendly to AGWDs.
- Community members play key role as the lead in either promoting or obstructing the fulfilment of SRHR for AGWDs
- Opportunities to access SRHR information and services for AGWDs are influenced by caretakers' and family members' perceptions and misconceptions about gender and age.
- The impact of disability-based discrimination, stigma, and abuse against AGWDs on their self-efficacy is influenced by community and family interactions.
- The families' knowledge, beliefs, and the existence of support and information systems such as SRHR information are critical factors in the ability to resist restrictive social norms and social barriers.
- Education, economic opportunities, accessibility of services, and the exposure to social networks are determinant factors of whether an AGWDs accesses health and other related information and services.

CHAPTER 1:

INTRODUCTION AND BACKGROUND

Over 1 billion people worldwide, around 15% of the world's population, are estimated to live with some form of disability. According to WHO, this number is increasing (WHO, 2011) (WHO, 2020). Due to a negative interrelation between disability, education, and economic opportunities, persons with disabilities often live in hard-to-reach communities and are disproportionately affected by extreme poverty. Strong evidence from literature and practice shows that the SRHR and needs of persons with disabilities, especially those who are most vulnerable due to poverty, continue to be largely unmet (WHO, 2011).

The aspirations, priorities, and concerns of many persons with disabilities about their SRHR health continue to be disregarded by caregivers, family members, communities, and health service providers. Additionally, social norms limit their sexuality, personal choices, and rights at many different levels – personal, interpersonal, and social. These societal stigmas and cultural stereotypes, rejections, and human rights violations have created barriers, preventing the fulfilment of the sexual and reproductive health and rights of persons with disabilities, and contributing to the misconception that they do not have the same right to sexuality, partnerships, and parenthood. This also increases the vulnerability of persons with disabilities to abuse (WHO, 2011).

These challenges span from limited access to reproductive health information and services, violence, and exploitation, to extreme hardship when faced with unplanned pregnancy (NCPD, 2021). The Kenya National Commission on Human Rights (KNCHR) report of 2012 showed that the adolescents lack easy access to quality and friendly health care, prevention, and treatment of Sexually Transmitted Infections (STIs), safe abortion services, antenatal care, and skilled attendance during delivery, which result in higher rates of maternal and perinatal mortality (KNCHR, 2012). Young persons with disabilities become sexually active and experience their sexuality early as other young people without disabilities. The early sexual debut occurs without adequate information on contraception, consent, and other rights, making them vulnerable to violations of their rights.

Sexual and Reproductive Health (SRH) services in Kenya are offered in health facilities and include counseling, information and services on family planning, information on prevention and treatment of sexually transmitted infections, MCH services targeting the PBF AGYW (pregnant and breastfeeding AGYW), HIV and AIDS services, mental health services, SRH / sexuality education, cervical cancer screening and HPV vaccine, and basic life skills. The Ministry of Education also provides age-appropriate Comprehensive Sexuality Education (CSE), plus there are organizations that provide SRH information and services to adolescent and youth.

The SRHR information and services remain largely inaccessible to persons with disabilities (PWDs) for many reasons including physical barriers, stigma and discrimination, lack of disability responsive information and communication materials, health-care provider attitudes and lack of knowledge and skills to handle PWDs among others. A world health survey found that PWDs were twice as likely to find health-care provider skills and equipment inadequate to meet their needs for information and services, three times as likely to be denied care, and four times as likely to be treated badly compared to non-disabled people. This roots from the misconception that people with disabilities are asexual in nature and are not sexually active, hence the lack of targeted programs for PWD SRHR information and services. This exposes them to several SRH related risks.

Despite the enactment of evidence-based policies to address this problem, the National Adolescent Reproductive health policy 2015, and the Reproductive Health Policy of 2007, 1adolescents in Kenya continue to face a high prevalence of adolescent pregnancy and low access to and use of adolescent sexual reproductive health services. Adolescent girls face the triple threat of pregnancy, GBV (gender-based violence), and HIV. Kenya ranks third highest globally in teen pregnancies. According to DHIS2, there has been over 300,000 adolescent pregnancies per year in the last three years, that is in 2019 there were 398,998 (32% of ante-natal care mothers), 332,217 (25%) in 2020, and 317,656 (21%) in 2021. About 3 out of 10 girls reported that they got married after the COVID-19 pandemic broke out. About 42% confirmed that they got married after getting pregnant.

Adolescent girls and young women (AGYW) are disproportionately affected by HIV compared to their male counter parts. According to Kenya ministry of health (MoH), 98 adolescent girls are infected with HIV weekly. In 2020 there was 10,422 new HIV infections among AGYW aged 15-24 years, this was more than twice that of the male of the same age group who had 3,988 new infections. Equally, there are 33,020 Adolescent girls (10-19 years) living with HIV (LHIV) compared to 19,099 adolescent boys LHIV (Source: 2021 NASCOP County Estimates)

According to the Kenya 2019 Violence against children survey (VACs), in the previous 12 months, sexual violence was experienced by 15.6% of females and 6.4% of males before age 18. Among the females who experienced childhood sexual violence, more than three out of five (62.6%) experienced multiple incidents before age 18. Among victims of childhood sexual violence, one in five females experienced sexual violence before age 13. Unfortunately, among the 18–24-year-old females, 9 in 10 victims who experienced sexual violence did not seek help.

The study outcomes for the groundbreaking research that was necessitated by the Covid-19 lock down measures also presented the "normalization of sexual abuse on teenage girls". While health is the priority at the time of experiencing sexual and gender violence, access to justice after the ordeal is essential in ensuring survivors' recovery and integration into the community without stigma. Significant work remains undone to ensure effective, well-coordinated response mechanisms that ensure survivors receive the appropriate support. This research also addresses issues around evidence, human social inclusion and better understanding the barriers, enablers, drivers, and patterns of access for AGWDs to SRHR. The findings of this research in Kisumu County aims to deepen the understanding of factors of exclusion and advance public awareness, acceptance, and support for AGWDs to access SRHR.

CHAPTER 2:

THE RESEARCH OBJECTIVES AND METHODOLOGY

THE RESEARCH OBJECTIVES

The following were the objectives of this research study conducted by Citizens Advancement Initiative (CAI); this is an organization that exists to respond to the limited collective engagement of special interest groups. CAI believes that promoting equitable access to quality SRHR is a critical element of the well-being of adolescent girls with disability and will improve their contribution to other aspects of life.

THE BROAD OBJECTIVE

The study sought to establish the level of SRHR awareness amongst AGWD, the AGWD SRHR experiences, and the accessibility of disaggregated informative data on AGWD ASRHR.

The overall aim is to advance the sexual reproductive health and rights of adolescent girls with disabilities by using the research data and information for advocacy.

SPECIFIC OBJECTIVES

- To establish the level of awareness on Sexual Reproductive Health and Rights (SRHR) among adolescent girls with disabilities (AGWD).
- To assess the level of meaningful involvement of AGWD in the design, implementation, monitoring, and evaluation of ASRHR policies and programs.
- To assess the accessibility of informative data on AGWD SRHR.
- To capture and document the experience of teenage girls living with disability.
- To interact with the Children's Act-2022, and the National Reproductive Health Policy 2022-2032, to explore the impact they may have on the adolescent living with disability SRHR

THE METHODOLOGY

STUDY SITE

The study was conducted in Kisumu County, which is one of Kenya's 47 counties and hosts the third largest city in Kenya. Kisumu is an urban city county and for this reason there is a large population of both local and immigrant communities. The County covers a total land area of 2009.5 KM2 and another 567 KM2 covered by water. The County has a diverse economic potential. It sits on the shores of Lake Victoria, making it a major fishing hub. Agriculture is another area of potential where rice is grown under irrigation in the Kano plains.

Most of the water for irrigation comes from river Nyando. Kano plains also hosts sugarcane fields that supply three major sugar factories located in the County. According to Kisumu CIDP (2022-2023), the county's youth is estimated to account for approximately 60% of the total population which comprises 1,155,574, with 556, 942 males; 594,609 females; and 23 intersex persons (2019 Kenya Population and housing census).

Disability demographics of the 2019 census capture Kisumu as key among the top counties in Kenya with high disability rate. Persons with disability in Kisumu are about 52,517 (5.4%) which is higher than the national average of about 2%. The County's contraceptive prevalence rate is 62.5%, with about 68% of women attending at least four antenatal care visits and only 69.5% of babies delivered in health facilities (NBS Demographic and Health Survey 2014 Release).

Adolescent girls in Kisumu County equally face the triple threat of pregnancy, violence and HIV/AIDS. According to NASCOP, in 2020 there were 9,158 adolescents, 10-19 years, living In 2020 Kisumu county recorded 17% of teenage pregnancy cases, with HIV in Kisumu County, among them 5,430 (59%) were girls. Equally the County had 853 new HIV infections among adolescents of 15-19years old, of which 743 (87%) were girls.

In 2020 Kisumu County recorded 6,514 (17%) adolescent pregnancy cases.

STUDY DESIGN

Qualitative research design was employed in the study where data was collected using three methods, namely:

- **Literature / desk review:** National and Kisumu County Adolescent & Youth ASRHR related policy /strategy documents, and publications, evaluation / program technical reports etc.

- **Key informant interviews (KIIs) targeting:** Ministry of Health Staff (County and Sub-Counties Reproductive health coordinators, County HIV and STIs coordinator, Health care workers that provide SRH services), Youth Champions male and female, Persons with Disability Champion and ASRHR Implementing partners

- **In-depth Interviews (IDIs):** targeting: Adolescent girls with disability, Adolescent mothers with disability (pregnant or with child), and Human Rights Defenders

The tools for the KII's and IDIs were based on content from peer reviewed journals, other published and anecdotal evidence from Kisumu County and Nationally. Observance of Covid-19 measures were put in place for these procedures as required.

The domains of interest in the tools explored the Adolescent girls with disabilities' awareness and experiences with matters ASRHR, the AGWD ASRHR and related services, programs, policies and roles of various stakeholders, the barriers, and enablers, and the availability of disaggregated informative data on disability and SRHR.

The study team got consent from participants and engaged a sign language interpreter for the KIIs and IDIs for the deaf participants to ensure that no one was left behind during the interviews. Secondary data extraction from the routine Kenya Health Management Information System (KHMIS) was conducted on the Adolescent sexual reproductive health services in the County and Nationally.

STUDY POPULATION

This research involved primary targets who were girls aged 10-19 years categorized into two; Adolescent Mothers with Disability and AGWDs irrespective of type of disability and location, with the aim of exploring how different factors and intersecting vulnerabilities influence their access to SRHR information and services. Since the primary targets were adolescent girls with disabilities, detailed informed consent measures were undertaken.

The secondary target group were namely, Healthcare Providers, Sub County Coordinators for Reproductive Health, HIV/AIDS, and GBV services, Youth Champions, Human Rights Defenders, Persons with Disabilities Champion, and Key AYSRHR implementing partners representatives.

STUDY SAMPLING, SAMPLE SIZE DETERMINATION AND RECRUITMENT

Three out of the seven sub-counties of Kisumu County were sampled to represent both urban and rural settings, plus other diversities e.g., Sub-counties close to the lake vs those closer to other land activities. The study population is outlined in table 1 below and comprises of:

- Nine Adolescent girls with disability (aged 15-19 years): three (3) per Sub-County
- Six Adolescent girls with disability (aged 10-14 years): two (2) per Sub-County
- Nine adolescent mothers aged 10-19years: three (3) per sub-County
- Six Health Care Workers: two per Sub-County
- Two Sub-County Reproductive Health (RH) Coordinators: One per sub-County
- Three Human Rights Defenders: one (1) per sub-County
- Two Sub-County HIV & STI Coordinators: one (1) per sub-County
- Two Youth Champions: one female, and one male
- One Persons with Disability Champion
- Two AYSRHR implementing partners representatives.

Table 1: Participants for In-depth Interviews and KIIs

Category of participants	Method of participant recruitment	Method of data collection	Number of participants: N/B: Each participant will be interviewed individually
1. Adolescent girls with disability (aged 10-14 years)	MoH and Organizations working with adolescents	In-depth Interviews	6
2. Adolescent girls with disability (aged 15-19 years)	MoH and Organizations working with adolescents	In-depth Interviews	9
3. Adolescent mothers with disability aged 10-19 years (pregnant/ with child/ has been pregnant before and lost a child/ miscarried	MoH and Organizations working with adolescents	In-depth Interviews	9
4. Human Rights Defenders	MoH and Organizations working with adolescents	In-depth Interviews	3
5. Health Care Workers who offer SRH services (e.g. MCH, GBV desks, Youth friendly clinics)	County and Sub-County Reproductive health coordinators	KIIs	6
6. Sub County Reproductive health or GBV Coordinator	County Reproductive Health Coordinator	KIIs	3
7. Sub County AIDS & STI Coordinator	County Director of Health / Chief Officer of Health	KII	1
8. Persons with Disability Champion	Sub-county Health Leadership	KII	1
9. Youth Champions	MoH / Organizations working with adolescents	KIIs	2
10. Organizations implementing ASRHR services	County Reproductive Health Coordinator	KIIs	2

INCLUSION AND EXCLUSION CRITERIA

This research was based on an eligibility criterion that was cognisant of other Human rights approaches and enhanced the LNOB criteria.

Inclusion criteria

- Adolescent girls with disability aged 10 – 19 years
- Residents of the Kisumu County for more than one year
- Willingness to take part in the study by giving informed consent or assent.
- Health Care Workers working in Kisumu County
- Ministry of health officials coordinating SRH and related services in Kisumu County
- Police officers working in Kisumu County
- Organizations providing ASRHR services in Kisumu County

Exclusion criteria:

- Children below 10 years
- Adolescent boys
- Adolescent girls without disability
- Non-resident of the six (6) counties for more than one year.

DATA COLLECTION METHODS

Research participants were selected based on pre-established demographic criteria. One week prior to data collection, selected mobilisers attained local approvals to inform key gatekeepers of the upcoming qualitative research and the intention to contact the various study populations.

The research team deployed the spin a bottle technique to determine the direction and snowball sampling technique to identify other respondents in the community. Mobilisers identified participants with disabilities who were either currently involved in PWDs activities, or who were already accessing SRH services, to help recruit other research participants.

Qualitative study data was digitally recorded, then transcribed and translated. This data was collected by a team of trained qualitative Research Assistants. Data entry and quality of data was ensured by the research supervisors.

Recurring themes and patterns in the data transcripts were identified. Codes were generated iteratively with input from questions in the interview guides and emergent themes. Coding and analysis were facilitated by qualitative analysis computer software.

To ensure reliability of the coding, two researchers independently reviewed the coding framework and identified themes and patterns.

ETHICAL CONSIDERATIONS

Ethical and scientific approval was sought from the Pwani University Ethics Review Committee and NACOSTI. Administrative permission to conduct the study was obtained from Kisumu County Government, Ministries of Health, and Interior.

In this study, the following human subject's considerations were observed.

Do no harm

This study involved procedures that did not physically harm the participants. Study participants were provided with all the information about the study and allowed to voluntarily make an informed choice regarding their participation including information about Covid-19 and measures to address this risk. Initial permission to conduct the study in the County, healthcare facilities, community, were obtained from County department of Health Research Coordinating unit. At facility level, permission was sought from the in-charges.

Participation in the evaluation

Participation was voluntary, and participants were free to exit the interviews at any point in time without any consequences. Sign language interpreter(s) were engaged to assist with the deaf participants. The adolescents with other forms off disabilities including physical and that need special assistance were assisted.

Informed consent

The participants who were selected to take part in the research had the work explained to them and a written informed consent obtained in English or Kiswahili from all participants prior to data collection. For participants that were visually impaired, and wished to make verbal consent, the verbal consent was recorded. Person's incapable or unwilling to consent either in writing or verbally were excluded.

The informed consent documents described the purpose of the study, the procedures that were followed, and the risks and benefits of participation. A copy of the consent was given to each participant in the official language chosen. The process of seeking informed consent involved presenting a detailed verbal description of the study as it is described on the printed, approved consent form. The interviewers emphasized that participation was voluntary, and that participants could refuse to answer any question or discontinue participation at any time without penalty.

Participants were informed of the procedures for ensuring confidentiality, including use of unique non-personally identifying identification numbers instead of names on research materials and maintenance of data in locked computer databases and locked filing cabinets in locked rooms. Minors were requested to give their assent and consent was obtained from their parent/guardian simultaneously. The deaf participants had the services of a sign language interpreter that was engaged by the research team.

Confidentiality of information

All information provided by participants was treated with utmost confidentiality. Individual names and any other identifying information are not revealed in reports and will not be shared with persons not directly involved in this study. All interview scripts were assigned unique codes in place of participants' names.

All interview documents, audio recordings and transcripts were securely stored in password-protected computers that were only accessed by the investigators. Any other hard copy materials that contain information from interviews e.g., field notebooks and printed transcripts were stored in locked cabinets in the Citizen Advancement Initiative (CAI)'s office under lock. Audio recordings were kept until they had been transcribed and data analysis and write up completed and thereafter destroyed as per the MOH recommendations for duration of storage for data.

STUDY LIMITATIONS AND MITIGATION MEASURES

Minimization of Risk

To mitigate the risk to community members and health facility personnel the study organizers took the following measures: (i) Did not record individual names on audio tapes and interview transcripts; (ii) used serial codes for sub-counties within a password-protected file stored separately from the collected data; (iii) held individual interviews in private space; (iv) stored all hard-copy data collection forms in locked cabinets in the research office; (v) stored all digital files (including audio files) on password-protected computers, with access permissions granted only to the evaluation team; (vi) destroyed digital files from devices used to temporarily store or transfer data files, once the transfer was complete; and (vii) assured that any publicly released report or presentation of the study findings sufficiently protected confidentiality of individual facilities and informants.

DATA MANAGEMENT AND ANALYSIS

All interviews were recorded, translated, and transcribed. While in the field, the research team conducted daily and weekly synthesis sessions to analyze the findings and begin deriving key findings.

During these sessions, the field team compared field notes, rapidly identified key findings, themes, and developed an overall picture of participants' feedback and experiences as reported by them. Following the production of field research reports, the research teams organized one reflection forum to analyze the insights, looking transversely across the themes into common and different barriers and enablers to access SRHR information and services for AGWDs.

The following themes emerged from this research and capture the insights that were gathered about user needs, desires, and concerns in family set ups, educational, professional, community, and health contexts with regards to SRHR information and services for AGWDs.

1. Key experiences and perceptions of AGWDs: this theme encompasses findings about the life conditions of AGWDs, their relationship with family members and others in society, and their aspirations, role models, and perceptions of self.

2. Inclusivity, Isolation, and communication challenges: this theme describes the implications of certain circumstances and events that AGWDs experience in their lives.

3. Awareness and experience on SRHR among adolescent girls with disabilities (AGWD): this theme includes findings on awareness levels among AGWDs on SRHR.

4. Access to relevant SRHR information, access, and utilization of SRHR services by AGWDs: this theme includes findings related to the specific experiences of AGWDs with the health system, health providers, health facilities and access to SRHR services.

5. Future perspectives of AGWDs: this theme relates to different aspects of the social lives of AGWDs with future perspectives that increase their social wellbeing.

CHAPTER 3:

GENERAL FINDINGS ON AGWDS

1. Key Experiences and Perceptions of AGWDs

This research showed that AGWDs are often given limited or no opportunities to acknowledge or develop their agency. Their gender, intersecting with factors such as age and disability, determined what their families expected them to do, and the role they should play in their community. AGWDs who were interviewed described low self-esteem, especially regarding their roles and aspirations in the community. They did not doubt their capability to work, but they clearly expressed insecurity about their ability to meet the gendered expectations and standards of the society in which they lived.

Despite expressing a clear interest in accessing SRHR services, they anticipate a future where comprehensive SRHR information or services are available and inclusive to all. This is possibly because many did not have access to information about existing services, did not have the choice to decide on when and could not access services independently. Some reported negative experiences at facilities, such as judgemental and discriminatory attitudes from health workers.

Many AGWDs did not consider the health support (maternal and antenatal care) that AGWDs receive as part of SRHR, or they considered SRHR services as something that was not for them. According to the research participants, across the county AGWDs experience difficulty carrying out physical activities as result of their disability, are generally subject to ill treatment and discrimination due to myths and misconceptions.

AGWDs (cognitive disabilities) are regarded as contagious or as having a curse or punishment that is transferable to their own children. AGWDs (physical disabilities) from birth are thought to only be able to deliver children with the same physical impairment. These misconceptions are passed on through negative attitudes in the community. However, these misconceptions come to the attention of PWDs and end up degrading their moral being and promote stigmatization. Some of the interviewed AGWDs mentioned that they were affected by the shame and fear imposed by these misconceptions, especially when they were aggressively verbalised to them.

2. Inclusivity, Isolation, and Communication Challenges

It was found during this research that AGWDs had limited social interactions with members of their community especially for the participants who did not work or attend school. Hence, they opt to stay at home due to the fact that they are often sidelined and isolated. The condition of isolation and difficulty in communication for AGWDs in this research was exacerbated by language barriers and the lack of social cohesion. Most AGWDs and their families have no access to radio, newspapers, and mobile phones hence unable to access information and knowledge on SRHR. In the literature, exclusion and isolation is described as a risk factor to violence and SGBV.

Some participants reported that AGWDs in Kisumu County were more prone to experience abuse by strangers, caregivers and as well as family members from within the household. Some of the abuse cases go unreported while those that get reported don't get justice. The decision of what to do in such cases was taken by a caretaker with authority. The AGWDs interviewed in this research did not refer to themselves as being in charge of the decision to seek medical or psychological care for themselves.

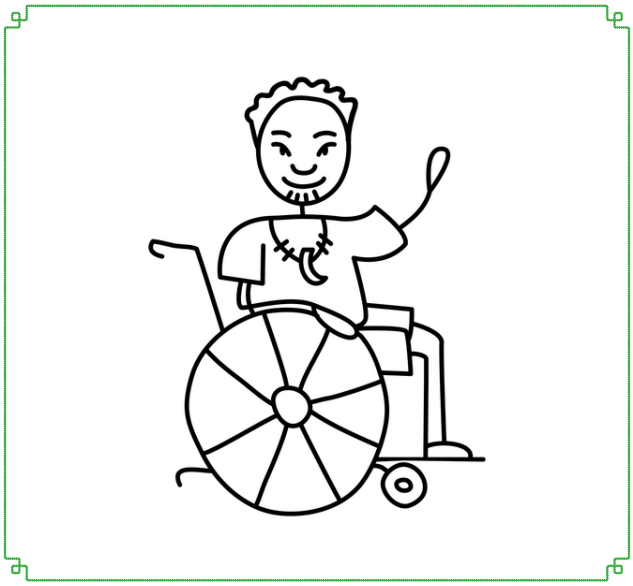
3. Awareness And Experiences On SRHR Among Adolescent Girls with Disabilities (AGWD)

It was noted during this research that AGWDs and Adolescent mothers with disability had limited knowledge or no awareness at all on SRHR services and had bad experiences when it comes to their social wellbeing. Lack of awareness and knowledge at all led to them having early sexual debut and some already had more than one child at tender ages. Lack of awareness led to low turn out to health facilities to SRHR services and GBV reporting.

This makes it hard for them to make informed healthy choices leaving them at the mercy of caregivers. To address this plight for awareness and improve their social wellbeing there is need to do inclusive programming by ensuring that there are tailored messages to help AGWDs. Lack of awareness and knowledge negatively impacts the lives of AGWDs promoting stigma, discrimination, GBV and lack of budgetary allocation since they are not able to come out and claim their rights.

AGWDs expressed that they tried engaging in intimate relationships, sexual rights, or pregnancy. Some of them mentioned that on awareness of their sexual rights, what to do in case of unwanted pregnancy, and where to go for sexual and reproductive health services. All other participants deferred the questions. Possibly influenced by the presence of caretakers, the interviewed women and girls showed a lot of discomfort when asked to address this topic.

The silence around women and girls' sexuality leads to very poor knowledge about their own bodies, sex life, and contraception, as well as reducing their awareness of potential symptoms or complications of a gynecological nature. As a result, in most cases, girls and women with disabilities lack the opportunity to take control of their sexuality, including their reproductive choices.



Additionally, health care workers in this research expressed a lack of knowledge and discomfort in how to communicate with AGWDs relying on family members to convey their messages to the person with disability who was receiving the service. They were often unsure if the family members were able to accurately communicate the needs of the AGWDs.

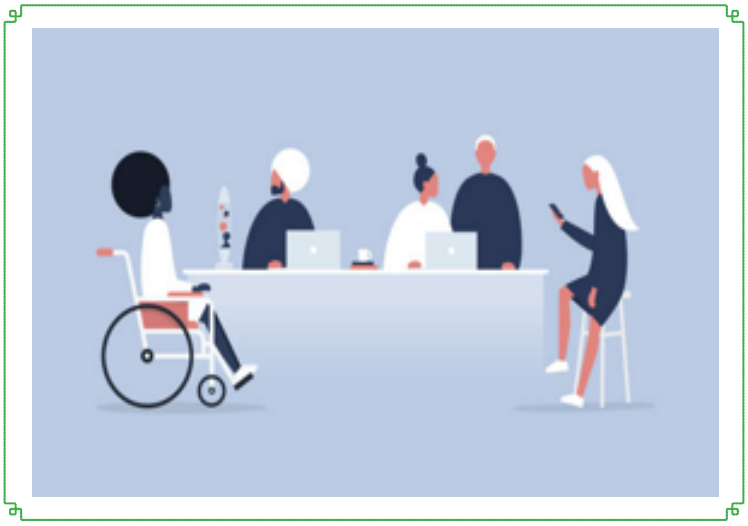
4. Access To Relevant SRHR Information, Access, And Utilization Of SRHR Services By AGWDs.

AGWDs Kisumu county have accessed some form of health service in the past. Amongst the services mentioned, that they have accessed include; SRHR related services, including HIV testing, family planning, ANC, MCH, cancer screening, PNC, or treatment following sexual abuse. It is important to note that, most often, accessing these services was the result of the initiative of family members or partners of AGWDs.

Overall, caregivers, family members and partners were shown to be very influential in determining when, where, and how often AGWDs participating in this research sought health services. According to interviewed health professionals, AGWDs request for long-term family planning methods, since this is seen as an effective measure to avoid pregnancies in the event that they are sexually abused. Sexual violence was also mentioned as the main reason that many families allow access to HIV testing for AGWDs.

Therefore, additional care in response to sexual violence, such as emergency contraception, safe abortion counselling, and treatment for STIs, will only be accessed if healthcare providers successfully get the requisite knowledge capacity to do so.

Research participants reported that health facilities are characterised by poor accessibility, both in terms of physical infrastructure, as well as negative experiences. Health care professionals reported having no formal training to meet the communication needs of a AGWDs, such as using sign language to communicate or using simplified language.



This resulted in communication difficulties and had an impact in the exercise of informed consent of girls and women with disabilities who were often excluded by family members in decision making. Some women or girls with disabilities were interested in SRHR services, but often ended up being excluded from access to information due to a lack of accessible SRHR information for them or their families. Women also reported facing physical barriers to accessing SRHR services.

5. Future Perspectives of AGWDs

In Kisumu county, most interviewed AGWDs were in school or were stay at home and already given birth. Schools, NGOs, and CBOs were described as a source of inspiration for AGWDs. Attending school was very important and highly valued by the participants. Nevertheless, many reported significant challenges in commuting or attending school as this is where events of insult and discrimination frequently occurred.

Many women and girls with disabilities who were interviewed said that they were prepared to cope and tolerate these events in order to attend school. AGWDs are less likely to attend school due to the schools' inability to adapt to their specific needs, such as help to commute to school, or appropriate learning support.

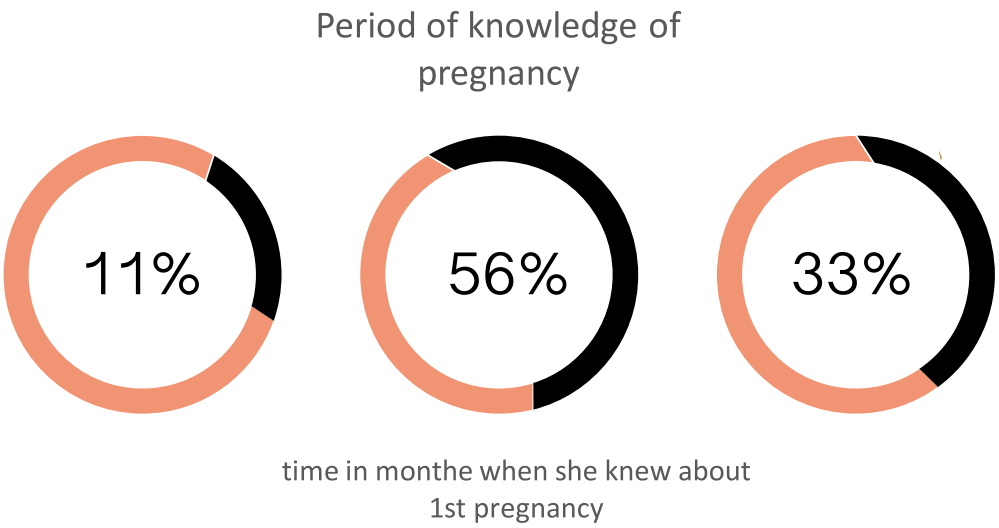
Greater access to education increases the chance to receive information, as well as raise awareness about SRHR and promote the confidence to realize these rights. These participants mentioned how they appreciated the groups and associations, primarily for the companionship and learnings on financial sustainability and economic empowerment.

CHAPTER 4

SPECIFIC FINDINGS REGARDING THE RESEARCH PARTICIPANTS

I. AGWDs age 10-19

15 AGWDs participated in this research as respondents with all of them aged 10-19 years old. All of them are school going and 13% of them reported that they belong to youth groups within Kisumu County. 93% of the AGWDs reported that they have attended health talks before organized by schools or other organizations including USAID and DREAMS project. Notably the AGWDs reported that the most common health concerns among AGWDs included lack of knowledge and information on menstruation and menstrual hygiene, teenage pregnancies, low self-esteem, urinary tract infections, accessibility to healthcare services, isolation, stigmatization, and communication barriers.

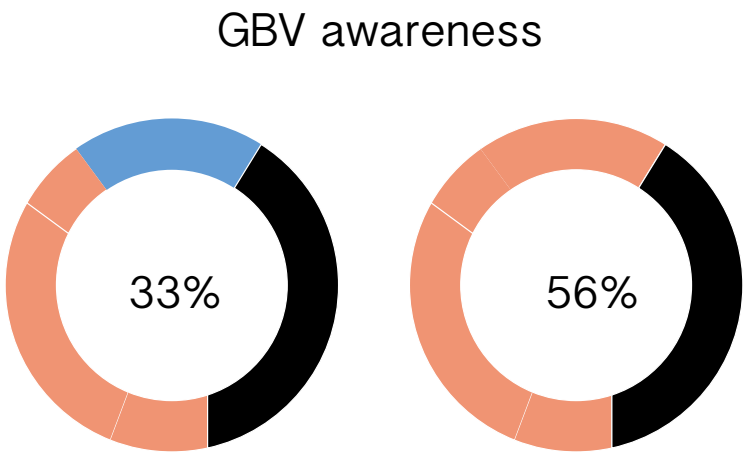


40% of the AGWDs reported to be having access to knowledge and information about SRHR but reported that the available channels in accessing this was not in a user-friendly manner to the AGWDs. They reported that they had caregivers (teacher, guardian, mother, sisters, and friends) they could talk to whenever they experienced menses or whenever they needed help on matters relationships and sexuality.

On accessibility to SRHR information they reported that they had limited access or no access to any source of information and were afraid of talking about it with their caregivers. AGWDs reported that they have gained knowledge on sexuality, early pregnancy, misconceptions of FP, menstrual hygiene, cancer screening and HIV/AIDS and STIs.

The respondents also reported that they face some major SRHR related issues for AGWDs including GBV, teenage pregnancies, lack of sanitary towels and other issues. Accessibility to SRHR services has been a challenge for AGWDs. But they reported that they had awareness on SRHR services available within health facilities although they had limited access to these services due to discrimination and stigma. Some of the factors that influence the capability of AGWDs to choose where to access SRHR services were listed by the participants and included proximity to the facility, confidentiality, service provider reception, caregiver willingness to access services and quality of services. This proved to be enablers for AGWDs to access SRHR services.

Barriers that hinder AGWDs to access SRHR information and services as reported by the respondents included, distance to the facility, waiting time at the facility, lack of service providers that can offer services to AGWDs including communication barriers, lack of resources and infrastructure for PWDs including wheelchairs, fear of anxiety, discrimination and stigmatization, cultural and religious beliefs.

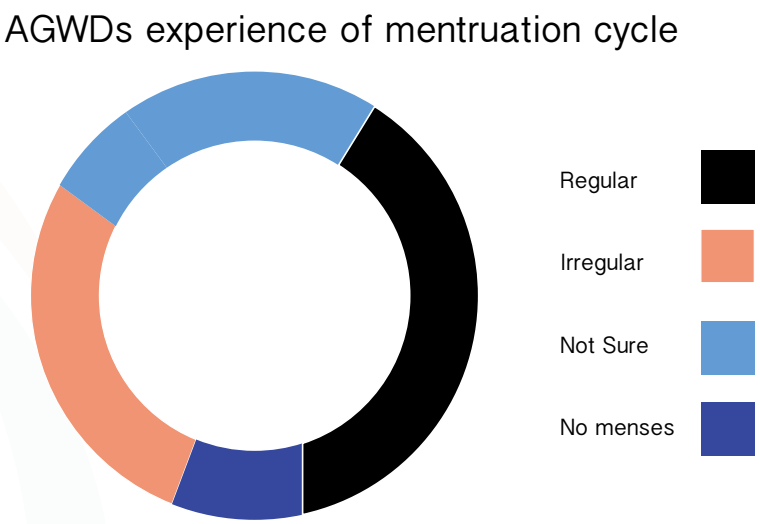


20% of the participants reported having been in a relationship before with 33% having had sex before but had no knowledge about use of condoms. 40% of them had knowledge on contraception and were aware of contraception methods including condoms and injections despite the fact they had not used them before but knew where the services can be obtained from.

All AGWDs reported that they were aware that they were at constant risk of getting infected with STI's and knew ways through which STI's could be transmitted. 93% AGWDs interviewed in this research reports that they were aware of GBV and knew how to respond to GBV whenever it occurred.

II. Adolescent Mothers with Disability

This research involved 9 adolescent mothers with disabilities aged between 16-19 years old with 56% of them reporting that they had bore one child, and 44% having more than one child. Since accessibility to SRHR information and knowledge is very key, most of the adolescent mothers with disabilities never knew when they had conceived. Attendance to MCH services has always been very key to the wellbeing of a pregnant mother and child.



Most of the AGWDs ought to be missing out on their first ANC visits and started during the second or third trimester of the pregnancy. The AGWDs mothers participating in this interview had attended 3 or more ANC visit and 88% of them had delivered in a health facility with the help of a midwife or a professional health care provider. With accessibility to HIV testing services the mothers reported having had a test in more than 6 months ago and could not even remember the last time they had a test.

Other SRHR services offered to the adolescent mothers included mental and postpartum depression screening, counselling services, cervical cancer screening, family planning, nutrition services, immunization, and PNC services and GBV screening services. Family planning knowledge was also reported among the adolescent mothers as they reported having information about FP methods available in health facilities including injectables, implants, condoms, COC, POP, IUD and ECPs.

III. Human Rights Defenders

This research targeted HRDs as participants, where 3 (1 F, 2 M) were interviewed. The HRDs interviewed play a critical role when it comes to Human rights and belong to the paralegal department as officers and volunteers. They reported that they had encountered cases concerning PWDs and some of the cases had already been closed with judgement given. They reported that they often get cases of GBV concerning AGWDs with different manifestations of disability. From the report given by the HRDs cases of GBV amongst AGWDs were very prevalent and could go unreported among the different communities of Kisumu County. With regards to reporting channels HRDs report that there were minimal reporting channels as some of the cases were being solved at community level with community members reporting, chiefs, peers, care givers and neighbors.

Perpetrators of GBV have proven to be to be stubborn when it comes to attacks on AGWDs with the perpetrators including boda-boda riders who ought to be offering transport services within the locality. close relatives, caregivers, friends, neighbors, and community members also appear to be offenders of GBV.

This research also focused on seeking to know whether there were systems in place to help access to justice and linkages for AGWDs whenever GBV cases occurred. Some of the measures put in place as reported by the HRDs included availability of Gender desks in police stations, availability of pro-bono lawyers within the county, medical legal doctors, and availability of CUCs. Some of the challenges sighted by the HRDs were lack of community buy in from community members in the fight against GBV on AGWDs, perceptions and presence of ADR mechanisms contrary to the law.

IV.HIV & STI Subcounty Representatives

During this research the researchers were interested in addressing issues around HIV to be able to address all components of triple threat. This research also focused on interviewing subcounty HIV representatives responsible for addressing HIV matters in sub counties across Kisumu County.

The interviewed representatives were responsible for coordination of provision of services to clients with HIV and TB and linkage of clients and community health extension workers (CHEWS) to facilities. From the responses it was noted that the major roles of the subcounty HIV representatives were coordination, capacity building, monitoring and evaluation of HIV services,

HIV/STI prevention and treatment, collaborating with community partners to create awareness and sensitization of adolescents, capacity building of healthcare workers on adolescent package of care, behavior change communication and counselling (health talks), cervical cancer screening and vaccination, ensuring easy access to FP options for PLHIV, ensuring youth friendly services, ensure availability of IEC Materials relevant to HIV programming.

The major health concerns among adolescent girls within the community was teenage pregnancies, HIV infections, early sexual debut STIs and GBV all these are enabling factors to triple threat. The respondents also agreed that AGWDs were also facing a myriad of issues that greatly affects their day to day lives including limitation of accessibility to SRHR services due to lack of social inclusion, GBV, forced and unwanted pregnancies, Inadequate empowerment/sensitization on rights, stigma and discrimination from fellow peers and community, inadequate involvement of the disabled adolescents in formulation of policies and advocacy.
It was noted that there were SRHR services provided at health facilities but not all of them were tailored to serve PWDs including AGWDs including but not limited to, FP, STI screening, MCH services, cancer screening and vaccination and IEC materials available that had no tailored messages.

100% of the interviewed representatives reported that AGWDs had no knowledge of SRHR services and were not able to access the services freely unless with the help of someone close to them, this implied that they had power to make personally informed decisions on what services they could access. Stakeholders within Kisumu County were working around the clock to ensure that SRHR services were available to all populations including AGWDs.

To help improve service provision it was suggested by the respondents that there should be improved allocation of funds towards supporting stakeholders, actively involve PWDs in community engagement and awareness creation interventions and strengthen and support of the relevant government coordination office for all partners implementing and participating in ASRHR activities.

Barriers to AGWDs accessing SRHR services at subcounty level seemed to be repetitive across all our respondents and included lack of awareness, cost of services, cultural/religious beliefs, distance from the service points, stigma and discrimination, quality of services, religious and cultural beliefs on disability, limitations on access to this information caused by the modes of communication used. GBV also appeared to be common to AGWDs and it was noted that most of the GBV cases go unreported, since families result to ADR mechanisms which in turn hinders access to justice for survivors promoting GBV.

As much as PWDs especially adolescent girls with disability were not involved in policy formulation, it was noted there were policies in place that addresses PWDs matters although they have not been disseminated. Recommendations from the respondents were that there was need for awareness creation among the adolescents with disability, there needs to be digital platforms with ASRHR information where the adolescents can have one stop comprehensive information and interact with peers for support and sharing, integration of HIV and RH services and construction of PWD friendly structures in health facilities.

V. Reproductive Health Subcounty Representatives

This research focused on reaching out to some subcounty teams in the department of health and gender responsible for GBV response activities in the sub county and networking with the relevant stakeholders to ensure service delivery to those affected by GBV in the sub county, demand creation, conducting sensitization and awareness creation, identifying cases and initiating referrals to service delivery points and linkages.

From the responses we noted that there were more than 100 cases of abuses to adolescents that had been reported at subcounty level in the last 6 months prior to this research with 30% of the cases being AGWDs. This research also deduced that the number of cases of abuse were high during the COVID-19 period with the restrictions leading to high number of cases hence exacerbating violence amongst adolescents. According the subcounty RH coordinators most of the cases were reported by relatives, community members, pastors, police, caregivers, and neighbors and that they were also leading perpetrators.

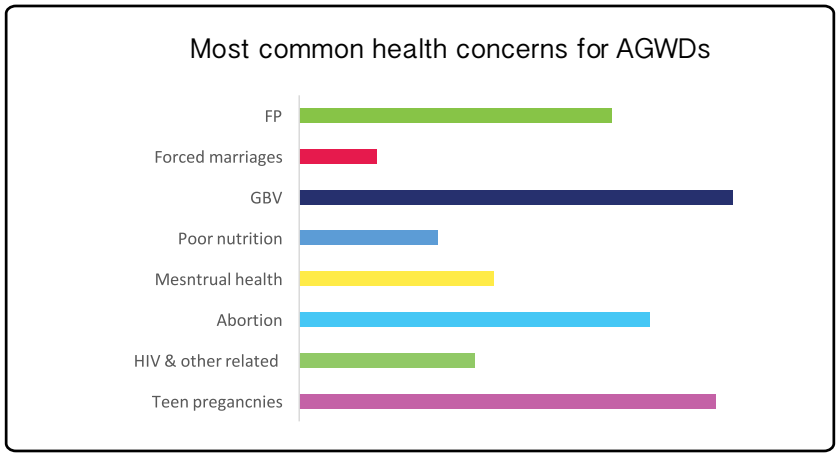
With regards to forced and early marriages at subcounty level, it was reported that there were cases of early marriages, but none had been reported to affect AGWDs. At subcounty level those interviewed reported that there were cases where AGWDs were forcefully or willingly allowed to use contraceptives with some being sterilized against their will.

Availability of GBVRC in Kisumu County triggered the inception of a toll-free number that could be used as a reporting mechanism in case of abuse. This research also reported that there were organizations, advocacy groups within Kisumu count but none was specific to address issues around PWDs.

Barriers to AGWDs accessing SRHR services at subcounty level include lack of awareness, cost of services, cultural/religious beliefs, distance from the service points, stigma and discrimination, quality of services, religious and cultural beliefs on disability, limitations on access to this information caused by the modes of communication used.

VI. Implementing Partners, Youth Champion, PWD champion and Community Health Care Workers

CAI interviewed partners implementing SRHR interventions; female respondents participated in the interviews. The partners reported that they are implementing programs aimed at promoting active and healthy lifestyles among girls within the urban and rural areas of Kisumu County and to improve literacy and the enrollment of adolescents to school.



Partners reported that some of the most common health concerns among adolescent girls in the community included, menstrual health and hygiene, sexually transmitted infections and urinary tract Infections, Gender Based Violence high levels of teenage pregnancies and poor nutrition.

AGWDs face a myriad of challenges related to ASRHR within Kisumu County. According to the partners interviewed AGWDs face stigma and discrimination at health facilities hindering their ability to access SRHR services, they lack information and knowledge on basic SRHR, lack of facilities that are inclusive and friendly to all populations with the health facilities, lack of basic SRHR commodities and they are more prevalent to GBV since they are more prone to be attacked by perpetrators.

We noted that some of the ASRHR services provided at health facilities that partners were aware of included ANC services, free children clinics, RH services including FP, VCT services and GBV services. AGWDs are not aware of their rights and services offered within the county as often the interventions put in place by stakeholders tend to discriminate against them hence hinders most of them from accessing information and awareness materials.Partners sited that the needs of AGWDs were not being met by the current interventions put in place hence need to embed messaging that is friendly to PWDs, packaging of SRHR services for inclusion and enhancing data generation to capture PWDs data.

Notably within Kisumu County there were no health programs specifically tailored to support AGWDs despite the existence of structured groups for PWDs and championing for health-related matters. Some of the groups included, Abled Differently, Heart to Heart, DREAM GIRLS, Binti Sphere, Miss Ability working in areas of health and SRHR advocacy. The stakeholders working on issues around AYSRHR within Kisumu County were not working together to address issues affecting AGWDs. There is a need to champion inclusion, in all aspects from planning, designing, management and service provision to foster a multisectoral approach.

Stigma and fear from the AGWDs, Some HTPS and beliefs that are geared to discriminate and inflict pain on PWDS, high cost of health services, lack of inclusive services at facilities and poor attitude from service providers towards the PWDs proves to be some of the barriers that affect AGWDs and creation of safe spaces where friendly and inclusive services are available to PWDs is a good platform that will enhance access to services. Additionally, AGWDs are majorly subjected to SGBV according to Partners working within the county and some of the survivor's fear reporting the cases as they at times are violated by their caregivers or people close to them.

There is need to do GBV/HIV awareness education/ creation among AGWDs to improve their capacities and enhance reporting pathways for GBV cases against PWDs whenever they occur. About relationship matters partners report that from their own knowledge AGWDs get into relationships and in most cases with their fellow PWDs and other abled beings, they undergo normal relationship challenges and are at times mistreated or treated fairly by their partners. Policy formulation has proved to be a critical aspect when it comes to sustainability of interventions, budgetary allocations by the govt and governance. Within Kisumu County several policies have been put in place to support ASRHR interventions.

Some of these policies include ASRH policy 2015, National guidelines on provision of youth friendly services, County SGBV policy, Kisumu County Gender mainstreaming policy. Unfortunately, there are no AGWDs specific policies articulated in the stated policies.

There is a need to ensure that AGWDs should be included in various stakeholder's forums and TWGs at all levels and included in community dialogues to address issues of stigma. Partners also recommended that service providers to be well equipped to provide services to PWDs, have PWD services accessible in a friendly environment like youth friendly facilities, curate messaging materials friendly to PWDs, support demand creation and linkages for PWDs, enhance social inclusion and hold DBs accountable to wards AYSRHR friendly programming and budgetary allocation.

CHAPTER 5:

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

This study explores the lives, habits, and ambitions of AGWDs , and their ability to access and utilize SRHR information and services in Kisumu county. The findings are presented here as described by themselves, caregivers, community members, gatekeepers, service providers, health care providers and others. The analysis of the interviews carried out reveal a number of different factors that influence AGWDs ability to exercise their rights and access SRHR information and services. It is important to look at how AGWDs perceive social norms, the way they comply or do not comply with them, and how this impacts their access to SRHR information and services.

This research confirms the findings of previous studies focusing on disability-based barriers AGWDs face to fulfil their rights of choice, sexuality, and access to services (WHO, 2009) (K.G. Santhya, 2015) (Mariani, 2017) (Rohwerder, 2018). This research also looks at the intersection of disability,gender, and other SRHR related intersectionality's including access to FP and MCH services.

This research also contributes to a deepening of the existing understanding about enablers and barriers of access to SRHR information and services for AGWDs. AGWDs in these contexts have very few chances to exercise their agency because they are economically dependent, socially isolated, and have difficulty finding peers to relate to, especially in rural areas and urban settings. Conservative norms related to gender, age, and disability intersect to increase barriers. These factors are major determinants to hinder access to SRHR information services.

Gender-based violence is extremely prevalent and can contribute to over-protection and social isolation practices by families. The stigma and shame related to GBV discourages women and girls with disabilities to access help, and fear of abandonment contributes to the view that GBV is almost inevitable and must be tolerated. Additionally, there are opportunities to improve the health system's response to the needs of AGWDs through more intentional efforts at delivery model and infrastructural levels. For example, antenatal, birth, and postnatal care are key entry points for pregnant AGWDs to access comprehensive SRHR information and services.

Notes for future research in motherhood and disability this research described the aspirations of motherhood from AGWDs. It did not, however, explore in depth the possible impact motherhood may have on the reported self-esteem of and discrimination against AGWDs. Additionally, further research should investigate how the context of isolation and discrimination against Adolescent mothers with disabilities affects the nature of mother-child relationships, and what forms of support are required by AGWDs to ensure their wellbeing. This research did not investigate the impact of disability on the masculinity of boys and men living with disabilities. It has nonetheless shed some light on the perception of how the disability of AGWDs amplifies and reinforces restrictive gender norms and negatively impacts social expectations. Further research should be conducted to understand the extent to which the same occurs with boys and men, and how this affects their conception of self-esteem.

Further research should investigate the impact inclusive peer groups and organised social interaction opportunities have on issues like stigma and isolation. Not enough has been said on the subject of gender age and disability intersectionality. Further research would help our understanding of this issue and how to better support families and their members with disabilities in meeting their SRHR needs.

1. Key gatekeepers of access SRHR information and services

In this research, family members and relatives play the strongest roles contributing significantly to the lives of the AGWDs including what they could expect from society, and whether or not they could access SRHR information and services. Their role can enable or limit access to SRHR services for women and girls with disabilities, depending on the prevailing social norms, culture, knowledge, experience, and attitudes. The centrality of influence of family members living within the household of AGWDs offers an opportunity to leverage a sense of responsibility and protection mechanisms within families.

From the interviews conducted during this research, it emerged that while families are the key gatekeepers to access services, they can often overlook the healthcare needs that AGWDs may have, including SRHR. The research showed that health providers also have decision-making power regarding SRHR services when they are visited by AGWDs and their caretakers.The lack of communication about aspects of sexuality and sexual and reproductive health, exacerbated by an overprotective attitude held by key gatekeepers, can further reinforce barriers for AGWDs to access information and services. In addition, if women and girls with disabilities do access health care facilities, health care workers themselves can also play an important role as gatekeepers to the services and information provided; as a result, AGWDs face more barriers to take control of their sexual lives and reproductive choices, with limited autonomy when it comes to self-identification of health problems and health seeking behaviour.

2.Socially Imposed Barriers And Enablers To Access SRHR Information And Services By AGWDs

As previously noted, families of AGWDs with disabilities are bound by different norms which are defined by their communities and societies. Research participants reported that the general social expectation is that AGWDs like any other woman, should get married, perform household chores, and respect religious, gender, and relationship-related norms, including motherhood. However, because of her disability, she is not socially expected to be a good intimate partner.

Misconceptions are often disability-specific and reinforce social isolation and the sense of dependency of AGWDs. This not only decreases the self-confidence of AGWDs, but reinforces the conceptions of dependency and isolation. In addition, misconceptions and social isolation are increasing the risk of violence and SGBV for AGWDs. AGWDs interviewed in this research choose to self-isolate and stay at home to protect themselves from public discrimination. This inevitably limits their opportunities to access SRHR information and services.

This research reiterates how important it is that family and communities understand that self-isolation is unhealthy. Without this understanding, they are more likely to follow restrictive social norms by making decisions on behalf of AGWDs denying them the opportunity to make self-informed decisions.

In addition to societal norms that are conservatively opposed to seeking and accessing SRHR services, there is a combination of additional barriers that prevent AGWDs from accessing SRHR services. Free access to services can only be effective by addressing all barriers, including a lack of availability, affordability, accessible information, and accessible and non-discriminatory services Additionally, health facilities in Kisumu county are described as inadequate and therefore unable to meet the needs of AGWDs, mostly due to experienced discrimination and frustration when using general services.

3. Impact Of Identified Barriers On Individual Perceptions And Sexual And Reproductive Lives Of Women And Girls With Disabilities

Lack of self-esteem is a recurrent characteristic that this study has identified among most of the interviewed AGWDs. This issue often translated into them doubting their "worth as a woman" and having limited expectations from life, including their marital life. Although the majority of AGWDs interviewed acknowledged their right to marry and have children, many felt the need to prove themselves in what the community consider the traditional female roles of wife and mother. In developing the level of empowerment and independence needed to autonomously seek for and access SRHR information and services can be particularly challenging.

More than unable or unwilling, AGWDs were reticent to express their wishes or feelings. They often seemed unable to oppose the decisions made on their behalf by the family members, particularly in relation to SRHR, or other components of life such as education and marriage. The isolation that AGWDs in both settings face, alongside the expectations of not disrupting the wellbeing of the family and the perception of being a burden, often leads AGWDs to accept the paternalistic attitudes of others. For the AGWDs involved in this research, the greatest internal barrier to health seeking behaviour was not the shame of being perceived as weaker and vulnerable – or the need to prove their strength to those close to them – but their generalised low expectations about what society could do for them, and the low expectations they had for themselves and the role they could play in the society.

Studies have found that AGWDs are at least twice as likely as women without disabilities to be victims of rape, sexual abuse, and intimate partner violence, with the most common perpetrators being men. The high prevalence of SGBV among the AGWDs interviewed for this research, around 45%, confirms the international data on sexual violence against persons with disabilities. Considering that disclosing such an experience is often perceived as very shameful and includes the risk of re-experiencing trauma, survivors often avoid talking about the abuse they have suffered. Moreover, the isolation and fear experienced by most of the AGWDs who were interviewed, as well as the widespread impunity of perpetrators and lack of protection mechanisms from abuse and violence, limit the opportunities to denounce violence and escape from situations of abuse.

4. Enabling Practices And Beliefs That Contribute To Women And Girls' Access To SRHR Information And Services

School was considered in both the rural and urban settings of Kisumu county, to be an enabling factor for AGWDs, given the structured intellectual growth and prospects of future remunerated work. However, the following limitations were identified: 1) limited effectiveness in increasing agency because school settings and the workplace are often environments where discrimination is experienced and reinforced

2) access to education and employment opportunities is strongly influenced by the attitude and behaviours of family members who may encourage AGWDs to take advantage of these opportunities, but also discourage them or create obstacles to prevent access.

The introduction of different information related to SRHR (i.e., menstrual cycle and hygiene, abstinence) is carried out through schools in Kisumu county ,but research participants also reported that this information not adapted to the communication requirements of persons with disabilities.

RECOMMENDATIONS

To have good programmatic interventions for successful delivery of SRH information and services to AGWDs, we recommend the following:

- Emphasise the relevance of SRHR to key gatekeepers, this will help them recognise the freedom of AGWDs regarding SRHR.
- Create and support existing peer models among families of AGWDs that stimulate engagement between similar age groups, geographic regions, and type of disability.
- Address the high risk of GBV for AGWDs with key SRHR actors (e.g. providing awareness sessions and including training modules on GBV and disability in training curricula for health workers). This cycle of violence is further perpetuated by insufficient attention and action on the issue of GBV for AGWDs.
- To reduce dependencies and increase access to SRHR information, there is need to facilitate access to economic, income generating opportunities and education for AGWDS reasonable adjustments to allow them be able to cope up with their daily activities.
- Encourage the integration of AGWDs into existing peer groups and address issues related to SRHR that incentivise and inspire their support to other women with disabilities. This experience may promote the exposure between those with and without disabilities, thereby creating reciprocity and empathy.
- In co-cooperation with SRHR stakeholders, there is need to develop strategies that focus on addressing restrictive social norms and misconceptions of disability through Social Behaviour Change and communication strategies.
- Support parents and caretakers, such as grandparents, in their role as key gatekeepers, to understand and respect the sexuality of AGWDs and to offer them guidance on the options they with regards to SRHR.
- Design health programmes that work together with AGWDS and their family members, targeting young and old men (i.e., fathers, brothers and husbands), and female caregivers of all ages. These family members have a great sense of responsibility that, if matched with a strong understanding of SRHR and the right to informed consent of AGWDs, can be leveraged to complement the role of health actors – thus, empowering families and communities with distinctive roles in health and wellbeing of their children and siblings and promoting their selfesteem, agency, and independence.
- Design inclusive outreach strategies and referral mechanisms that are empathetic and sensitised to the access challenges of AGWDs. It would be important to explore the impact of targeted outreach strategies such as door to-door visits, as well as the advantage of working with peers with disabilities in those outreach activities

- Encourage open forums for discussion and dissemination of good practices among health care workers, where AGWDs can participate and contribute. This gives visibility among peers and reduces misconceptions of health care workers. By offering solutions that enhance the social capital of health providers and reward efforts for inclusivity, they are more likely to proactively seek improvements in their services. with disabilities in both urban and rural settings, as a key factor to increase communication opportunities and participation in social networks.

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Citizen ADVANCEMENT INITIATIVE

AMERICAN JEWISH WORLD SERVICE

SRHR AND DISABILITY

July 2023

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