SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENT GIRLS
AND YOUNG WOMEN WITH PSYCHOSOCIAL DISABILITIES

A Survey Report
On the Extent to which Adolescent Girls and Young Women
(AGYW) benefit from existing SRH Services in Jinja District

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Prepared by:
TRIUMPH UGANDA
Mental Health Support and Recovery Program
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Introductory Message

It gives me great pleasure to present the findings of this baseline survey focusing on the extent to which Adolescent girls and Young women with psychosocial disabilities benefit from the existing Sexual and Reproductive health services in Jinja. Sexual rights are human rights that are related to sexuality and are closely related to the right to life, home and family, liberty, security and body integrity. Access to SRHRs is fundamental to development, encourages longevity and improved quality of life of the entire family.

Currently, there is a significant unmet need for sexual and reproductive health services in Uganda across all age groups. Demand for HIV and SRHR services is growing as a result of the age structure of the population. 49% of Uganda’s population is under 15 years of age. In subsequent years a growing proportion of the population will be sexually active and of reproductive age, there is need for urgent action to be taken at all levels targeting all the diverse populations.

This is probably the first survey specifically focusing on women with psychosocial disabilities and their sexual and reproductive health. This to me is a major milestone because people with psychosocial disabilities are among those who have been relegated to the peripheries of society and this is an opportunity to enhance inclusion.

The benefits of integrating SRHR at a community level have not been fully realized in Uganda and there is significant room to improve integration in CBO service delivery. CBOs are the drivers of social change within communities in Uganda and are the leading health transformers through creating awareness, sensitization and adoption of social behaviors that are beneficial for health service access. In addition, if CBOs are supported it can enhance their advocacy capacity and skills to engage the local decision-makers and gatekeepers to support SRHR including putting these needs on the agenda of local government development plans.

The study has provided data to support the process of effective support, empowerment and inclusion of people with psychosocial disabilities. This is reechoing the “Leaving no one behind” slogan of the SDGs promotion initiative. The data also provides opportunities for service providers to in future design interventions that are appropriate to meet the unique needs of people with psychosocial disabilities.
I would also like to invite the media, researchers and others organizations to use the data to especially contribute to the process of upholding the rights of persons with psychosocial disabilities.

I also take the opportunity to thank the different agencies and individuals that availed time and information without which the data in this report would not have been obtained. Special thanks go to the DHO, the CDO, Uganda Police, TASO, FLEP, AIC, Kakira, Bugembe and Walukuba Health Centers, Jinja Referral Hospital, SALVE, CRO, Walukuba Masese Child development Center, and ATANEKONTOLA. I also want to extend special thanks to, The Jinja District Disability Council and the Human Rights Office Eastern Region office. Your support made this survey possible. I cannot forget to thank the members in the psychosocial disability fraternity whose stories and involvement in the FGDs gave a human face to the reality of issues concerning sexual and reproductive health of people with psychosocial disabilities.

May God bless you all.

Robinah Alambuya
Executive Director
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List of Abbreviations

AGYW – Adolescent Girls and Young Women
AIC – AIDS Information Centre
AIDS – Acquired Immune Deficiency Syndrome
CDO – Community Development Office
CRO – Child Restoration Outreach
CRPD – Convention on the Rights of People with Disabilities
DRF – Disability Rights Fund
FLEP – Family Life Education Program
HIV – Human Immunodeficiency Virus
DHO – District Health Office
LAMIC – Low and Middle Income Countries
PSD – Psychosocial Disability
SRH – Sexual and Reproductive Health
TASO – The AIDS Support Organization
UN – United Nations
1.0 EXECUTIVE SUMMARY

In the last decade there has been growing recognition of people with psychosocial disability as a marginalized group who have experienced sustained human rights violations. People with psychosocial disability have historically also been excluded from the disability and development movements and health agendas of most low and middle income countries (LAMIC). The most significant barrier to inclusion is the pervasive negative attitudes and discrimination towards psychosocial disability, which along with other barriers (physical, accessibility of information, socio-economic, legislative) results in exclusion across all areas of development including health; education and livelihoods; social inclusion; legal capacity; and restriction of civil and political rights, including participation in mental health policy development (Drew et al. 2011; Kleintjes et al. 2013).

In the disability fraternity, people with psychosocial disabilities are among the least understood. Several programs targeting people with disabilities have not specifically addressed the needs of people with psychosocial disabilities. Beside, by the nature of their vulnerability, they are at higher risk of having their sexual and reproductive health rights violated because perpetrators hide under the guise of unsound mind of their victims.

The concluding observations made by the committee for the UN convention on the Rights of People with Disabilities (CRPD) among others faulted the Uganda government on the lack of information on accessible health care facilities for persons with disabilities and the absence of measures to ensure that information and services on sexual and reproductive rights are accessible. The committee recommended that the state adopts measures to ensure that all education, information, health care and services relating to sexual and reproductive health, HIV and AIDS and sexually transmitted infections, including treatment, advice and counseling are made accessible to persons with disabilities in particular women and girls with disabilities in age-appropriate formats in both rural and urban areas.

Information on the sexual and reproductive health of people with psychosocial disabilities is contained in anecdotal evidence. Part of TRIUMPH – Uganda’s mission is to come up with interventions that are based on evidence based data. As part of the genesis towards this initiative, TRIUMPH – Uganda conducted a base survey to establish the extent to which adolescent girls and young women are benefiting from the existing sexual and
reproductive health services in the district of Jinja.

The analysis of service provider’s accounts and the accounts of people with psychosocial disabilities suggests a range of factors undermining provision of high quality sexual and reproductive health services to adolescent girls and young women with psychosocial disabilities. Service providers often have limited awareness of the sexual and reproductive health needs of women with psychosocial disability. The capacity of service providers to appropriately respond to the needs of women with psychosocial disabilities is limited. Service providers have had very little training in relation to disability and have limited access to resources that would enable them to provide a service that appropriately fits the needs of adolescent girls and women with psychosocial disabilities. It was also noted that some service providers hold prejudiced attitudes towards women with psychosocial disabilities seeking sexual and reproductive health services.

2.0 INTRODUCTION

Psychosocial disability is an internationally recognized term under the United Nations Convention on the Rights of Persons with disabilities. It is used to describe the experience of people with impairments and participation restrictions related to mental health conditions. It refers to the social consequences of disability and the way that one’s life is impacted upon due to mental illness. People with PSD find it much more difficult to set goals and make plans, engage in education, training, decision making, employment and other social and cultural activities. Psychosocial factors influence different types of mental illness to varying degrees. Some conditions involve significant long term psychosocial impact in comparison to others. That is why care needs to be taken to meet the unique needs of each individual.

Psychosocial disability has been conceptualized in different ways: from a continuum of tension, stress and distress, to a biomedical understanding associated with mental health conditions including schizophrenia, bipolar disorder, depression and substance misuse. In this paper, the term ‘psychosocial disability’ has been used to refer to people who self-identify and/or have received a diagnosis of a mental health condition and who have experienced negative social effects including prejudice and discrimination and, in many cases, negative impacts from interactions with health systems. Discrimination and subsequent exclusion is often embedded in widespread debate around the cause of mental
impairment and unjustified assumptions regarding the capacity and potential of people with psychosocial disability (World Health Organization 2011).

Paul Deany, DRF Program officer had this to say;

“If disability is one of the great human rights challenges of this century, then within this, psychosocial disability remains one of the most challenging and misunderstood areas of disability”.

Psychosocial disability takes different forms; it can be episodic, invisible and often not well identified. It may be hidden by individuals or their families out of shame, denial or fear of incarceration. This fear is reinforced in an environment of repressive laws, stigma and systemic abuse. Throughout history persons with psychosocial disability have often been shunned and demonized. The greatest challenge that people with psychosocial disabilities face is not their disability per se but the many barriers that society and institutions put ahead of them. The onus therefore is for the psychosocial disability fraternity to focus their energies on how society treats them.

Mental health conditions can differ in duration, are often relapsing and remitting in nature, so varying in the degree of disability they cause at any point in time. It is important to note that not everybody who has a diagnosis of a mental health condition would be considered to have a psychosocial disability, identify as having a disability, or subscribe to a medical model of mental illness or impairment. Many countries including Uganda do not have accurate information on the prevalence of disability in general, and countries which have conducted census surveys inclusive of disability may not have appropriately or effectively collected information on psychosocial disability if at all. This limits the capacity of governments and development actors to address the needs of, and to measure, the inclusion of people with psychosocial disability (Goujon et al. 2014).

International development actors are increasingly recognizing the need for targeted action to address discrimination and other barriers to ensure people with psychosocial disability are included in, and able to benefit from, development programs (WHO 2010; Hann et al. 2015). The aim of this study was to document the extent to which persons with psychosocial disabilities benefit from existing sexual and reproductive health services in the district of Jinja.
3.0 METHODOLOGY

The baseline survey was conducted as part of a larger one year project aimed at contributing to the process of improving the health status of AGYW with psychosocial disabilities in the district of Jinja. It is envisaged that the project will provide a platform for advocating for better access to sexual and reproductive health services for persons with psychosocial disabilities in Jinja district as outlined in CRPD Articles 25 (Health), 23 (Respect for home and family) and 12 (Equal recognition before the law).

3.1 Survey Goal and Objectives
The survey goal was to document the extent to which adolescent girls and young women benefit from existing SRH services in Jinja District.

Objectives

1. To establish the existing SRH service delivery points in the district and the services offered.
2. To establish the nature of services offered to adolescent girls and young women with psychosocial disabilities.
3. To establish the challenges faced by the service providers and AGYW in the process of accessing SRH services.
4. To make recommendations on possible ways of improving SRH service delivery to AGYW with psychosocial disabilities.
3.2 Approaches

The study took a qualitative approach. The data was analyzed to identify key themes in participants’ discussion of service provision to adolescent girls and women with psychosocial disability.

3.3 Data Collection Methods/Techniques

3.3.1 Key Informant Interviews;

Key informant interviews were successfully conducted with 19 individuals who hold pivotal positions in sexual and reproductive health service provision in different sectors; both government and NGOs.

3.3.2 Focus Group Discussions;

Three Focus Group Discussions were conducted. The FGDs were composed of women with psychosocial disabilities and care givers of people with psychosocial disabilities, men with psychosocial disabilities and a group of adolescent girls and young women with psychosocial disabilities.

3.3.3 Desk Data Review;

Literature on previous studies and publications was reviewed to explore existing information and interventions on SRH of people with psychosocial disabilities.

The average duration of the interviews was forty minutes and focus group discussions lasted approximately 90 minutes. In both the interviews and the focus group discussions, the participants were asked about the SRH services they offer and whether these services are used by girls and women with psychosocial disabilities. Their perceptions about psychosocial disability and SRH were explored including their experiences in provision and/or receiving of SRH services. An exploration was also made about knowledge on SRH rights and the CRPD. Respondents were purposively enlisted from organizations providing SRH services.
4.0 RESULTS
4.1 SRH Service Delivery Points in Jinja District

The survey revealed that Jinja has several SRH service delivery points; the services are offered by both government and NGOs. Below is the summary of some of the SRH service delivery points and the services they provide.

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>SERVICES PROVIDED</th>
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| JINJA HOSPITAL                | • Education on family planning methods and child spacing  
                                 • Counseling to support informed decision making on family planning method to use  
                                 • Post coital pill for those who have been raped  
                                 • ARVs and Post coital pill for those who have been exposed to HIV  
                                 • Handling pregnant adolescents  
                                 • Ante and post-natal care  
                                 • Handling premature labor and abortions/miscarriages  
                                 • Post-delivery problems e.g. fistula  
                                 • Dysmenorrhea  
                                 • Conducting deliveries both normal and caesarean  
                                 • Comprehensive Post-natal care  
                                 • Adolescent clinic focusing on  
                                   - Group education for behavior change  
                                   - HIV testing  
                                   - Counseling on common problems of puberty |
| AIC (AIDS Information Centre) | • Comprehensive Sex education capturing aspects of sex and sexuality, gender issues, safe sex, culture and sexuality, alcohol and drug abuse, rights and responsibilities.  
                                 • Community awareness through peer support groups  
                                 • Counseling and testing for HIV and STIs  
                                 • Peer support counseling  
                                 • Reproductive health counseling  
                                 • Family planning |
| **TASO** | • Cervical cancer screening  
• Family planning |
|---|---|
| | o General counseling  
o Adolescent counseling  
o Community sensitization |
| **SALVE** | o Counseling for girls on the street  
o Menstrual hygiene for girls on the street  
o Protection from sexual violence for street children  
o General counseling for street children  
o Enhancement of reproductive health through rehabilitation and resettlement of street children |
| **Health Center III and IVs** | o Counseling services for young mothers  
o Child spacing  
o HIV testing services and ART clinics |
| **Family Life Education Program (FLEP) - targets 10 – 24 year olds** | o Provides age appropriate family planning services.  
o Information on SRH  
o Maternal Child health care  
o Services to mitigate and support victims of Gender based violence  
o Referrals for HIV testing and STIs |
| **CRO – targets adolescents and women in the community** | o Health talks,  
o Referral for HIV testing  
o Referral for treatment of STIs  
o Community outreach  
o Education on family planning  
o Provision of sanitary pads |
| **Human Rights Office** | o Sensitization on human rights  
o To monitor human rights  
o To advance human rights |
| **Other organizations like AMPCAN, AOET, Masters Seed, ATANEKONTOLA, Uganda Police** | o Medical examinations in the event of rape  
o Transport facilitation for witnesses to come to court  
o Supporting the police when they go to villages to do investigations related to sexual abuse |
The survey showed that the private center accounts for 82% of the SRH service centers and the government accounts for 18%. Jinja hospital was the main referral center for SRH issues.

4.2 Services for People with Psychosocial Disabilities

The survey revealed that the services provided targeted the general community and if anybody with a psychosocial disability came for a service at any of the service centers they are generally catered for. The service centers however do not have services specially tailored for people with psychosocial disabilities. In some places some disabilities were taken care of like in some places there would be a person to for instance use sign language for those with hearing impairment. The community and service providers have limited understanding on the dynamics of psychosocial disability. In some cases the service providers preferred to stay clear of people with psychosocial disabilities for lack of ability on how to handle them. Suffice to note is that there are some referral networks in some of the service centers. Individuals who were identified as having psychosocial disabilities were often referred to the regional referral hospital specifically to the mental health unit where there are some
personnel trained in handling people with mental health challenges. The referral hospital also runs an Adolescent mental health clinic once a week.

It was noted that most of the service centers did not have people that had the capacity to handle people with psychosocial disabilities. The only place identified in the survey that had personnel that had skill in handling people with psychosocial disabilities was the mental health unit in the referral hospital. The different service centers however, referred people with psychosocial disabilities whom they could not handle to the mental health unit. There were also no programs aimed at building the capacity of the different service providers to effectively work with People with psychosocial disabilities.

Discussions with people with psychosocial disabilities and their care givers revealed among others that the people with psychosocial disabilities were aware of the different SRH service delivery points. They were able to generate a long list of service providers including the media fraternity like KO TV and NBS Radio whose talk shows had done a lot in meeting their information needs on SRH issues. They also identified village meetings as another service provider.

4.3 **SRH Needs of Women with Psychosocial Disabilities**

An exploration was made regarding the different needs that are presented by adolescent girls and young women with psychosocial disabilities at the different service centers. The needs included the following:

4.3.1 **Rape and defilement**- it was noted that this is a common problem among adolescent girls and women with psychosocial disabilities. Some sectors in society look at adolescent girls and young women with psychosocial disabilities as sexual objects to be used as and when one feels like. In some cases the abusers do it out of sheer curiosity. The abusers want to find out whether these ladies are “also sexual beings” like other women. Even in the police, statistics showed that the majority of cases of girls and women with psychosocial disabilities presented cases of rape and defilement. One of the focus discussion groups was charged with emotions as
members shared some of the painful experiences they had gone through including rape. Unfortunately they did not have psychosocial support to help them go through these traumatic times.

4.3.2 **Pregnancy** – the girls and women also presented with pregnancies. In some cases, the person responsible for the pregnancy was unknown; especially in cases of rape. In other instances the people responsible were not willing to identify with the mothers because of the belief that “I cannot stand being associated with a person with a mental health problem”.

4.3.3 **HIV, STIs and other infections of the reproductive tract** – during one of the FGDs a participant (girl with psychosocial disability) said, 

“There is something I am going through but I have never shared it with any one, not even my grandmother with whom I stay because I fear. Strange dark colored water comes out of my private parts”.

Another girl in the group said,

“Why do I get sores in my private parts, which come and disappear without treatment?”

It was discovered that some of the girls were suffering silently with different infections. The FGD turned out to be a forum where they had opportunity to share out some of the things which were silently tormenting them.

4.3.4 **General body weakness** – in some instances the girls and women present with a general feeling of weakness. In those cases they are treated depending on what the clinical investigations come up with.

Often times the girls and women with psychosocial disabilities are taken to the service centers by someone especially family members. This is a major pointer to the cardinal role played by the “significant other” in the lives of people with psychosocial disabilities. It is common for the presenting issue to be tabled by the person accompanying the person with a psychosocial disability to the service center point.

4.3.5 **Family Planning Services** - Some of the girls and women presented needs for family planning services. In most cases it is the family members who request for
contraception services to be given to the person with a psychosocial disability. The purpose of this was to primarily prevent pregnancy in the event of rape. Relatives of the girls and women with psychosocial disabilities are aware of the extent of vulnerability to sexual abuse to the people with psychosocial abilities. So as a quick solution to prevent pregnancy, a decision to get onto one of the available contraceptive methods available is taken. This is often times without the consent or consultation with the recipient. The decision is taken in good faith however it violates their rights to decision making. Incidences like these call for the concept of supportive decision making. The intervention may prevent pregnancy but it does not protect the girls and women from sexually transmitted infections like HIV and others.

4.4 CHALLENGES FACED BY AGYW WITH PSDS IN THE SERVICE CENTERS

During the survey it was noted that none of the service centers go out of their way to frustrate those with psychosocial disabilities or to deny them service. However despite the good faith and positive attitude of the service providers, some challenges were noted which include;

4.4.1 Stigma

People with psychosocial disabilities face some of the worst forms of stigma from society and this has also unfortunately come from some of the SRH service provision centers. This comes partly from ignorance on how to handle people with psychosocial disabilities and the belief that they are of unsound mind and therefore cannot come up with any coherent information. A senior clinical officer in the referral hospital said people with psychosocial disabilities need to be listened to because most times they tell the truth. They can for instance truthfully point out a person who has sexually molested them regardless of how incoherent their statements are.

Cynical and sarcastic statements from the service providers have made them feel insulted and feel of less value. They are made to feel like they do not have SRH rights
like their counterparts without psychosocial disabilities. In some instances they are not believed. Whatever they say is dismissed and regarded as a function or result of an unsound mind.

4.4.2 Inability by service providers to handle PSDs

Some service centers have focal people for people with disabilities; however they do not have focal people for people with psychosocial disabilities. Some units especially the health centers have clinics for people with psychosocial disabilities on designated days of the week and they provide psychiatric services. Most of the SRH service providers do not have people who have the skill in handling people with psychosocial disabilities. As a result of ignorance and lack of expertise, the rights of people with psychosocial disabilities have been unknowingly and unintentionally trampled upon. There is only one place (mental health unit) where they can be referred and sometimes the numbers in that unit are much bigger than the capacity of the available staff to handle. Beside the mental health unit concentrates on mental health issues and does not have specific focus on sexual and reproductive health.

One responded said,

“I was given medication without the doctor bothering to find out whether I was pregnant or not; as a result, I ended up miscarrying”.

If someone in the mental health unit has a major SRH issue they are referred to other departments in the hospital which handle SRH issues. This creates a kind of paradox because the place they are being referred to has specialists in SRH issues but are not good at handling people with psychosocial disabilities.

The people with psychosocial disabilities felt they needed to be allocated more time to express themselves before the service providers, this however is not possible due to the numbers to be attended to and also due to the ignorance of the service providers on the aspect of spending more time with PSDs if one is to get adequate information from them.

4.4.3 Discrimination

Discrimination and lack of understanding of psychosocial disability is a major factor contributing to exclusion (Aleisha et al 2016). The adolescent girls and young
women with psychosocial disabilities also revealed that they face discrimination in the service centers. They are often relegated to the side lines and attended to last. This sometimes happens due to the false notion that they have no feelings and have no sense of time or space so they can as well be attended to anytime. Sometimes the discrimination comes due to a lack of understanding on the aspect of psychosocial disability.

4.4.4 Inadequate family support

It was also noted that some of the care givers are ignorant of even of the basics of caring for people with psychosocial disabilities. As a result, they misunderstand issues about dosage and review and consequently fail in their duty to provide the much needed support. Sometimes they believe in superstition and witchcraft and ignore the medical instructions in preference for traditional healers' instructions which are often times counterproductive. On top of that care givers are also traumatized by the situation of their relatives and as a result they do not give appropriate support. In some instances the care givers are rough and intimidating and this works to the disadvantage of the PSDs.

4.4.5 Communication barriers

It was also noted that people with psychosocial disabilities find it challenging to express themselves to the service providers in a way that can be clearly understood. This comes against a backdrop of belief by some service providers that people with psychosocial disabilities do not understand. This makes it hard for them to be believed. Sometimes they are just ignored. The situation is worse if the person comes looking disheveled.

4.4.6 Initial Presentation

Initial Presentation in this case is referring to the state in which the person with a psychosocial disability presents at the service center. Sometimes they come when they have an attack of a mental condition. During this time they are considered loud, unruly, violent and disruptive. In such situations, the response has been to get “rid” of them as fast as possible or send them to the mental health unit. When a subsequent visit takes place when the initial attack has been managed, there is a
tendency for the service providers to stick to the previous state in which the person was at the initial presentation time. As a result the person is handled with suspicion, fear and mistrust. A respondent during the survey had this to say;

“You can never be sure of your security when you are with a person with a psychosocial disability”.

4.4.7 Lack of comprehensive service package

There is a general lack of a comprehensive service package meant to meet the unique needs of people with psychosocial disabilities. A respondent said that there are for instance no professional counselors at the service centers. This makes it difficult to ably support people with psychosocial disabilities. There are also no specific programs or information delivery outlets that are targeting people with psychosocial disabilities. They are expected to fit in with the rest of society and yet they have unique needs. The survey team did not find any capacity building program meant to offer support to people with psychosocial disabilities.

4.4.8 Attitude of service providers

During the survey, it was noted that the attitude of the service providers was on two sides. On one side, there were those who reported a positive attitude and demonstrated openness in handling people with psychosocial disabilities. On the other side especially from the people with psychosocial disabilities it was reported that the service providers had the feeling that “these people do not understand”. A respondent said,

“They are given injections to stop them from conceiving”. There is a lot of stereotyping going on. Another respondent said, “Who tells you I don’t have a brain? I may have issues but my brain works and I can make some decisions”.

4.4.9 Inadequate community support

The service providers need the support of the community to compliment the services offered because ultimately the PSDs live and belong to the community. It was however noted during the survey that the communities have in some instances proved to be counterproductive to PSDs. Perpetrators of abuse are protected and
hidden by the community. Even when they report incidences of abuse they are not taken serious.

4.4.10 Economic situation

During the focus group discussions, the participants emphasized their low economic status as a major impediment in accessing SRH services. One respondent said,

“This (people with psychosocial disabilities) low economic status increases their vulnerability to abuse. There is need to empower them economically so that they can meet some of their needs”

4.4.11 Rights Issues

Fundamentally, the onus is on every individual in society to promote and protect human rights irrespective of who the people are. The survey revealed that the respondents had some knowledge about SRH rights. The most knowledgeable people about rights issues were those in the disability fraternity. Some of the rights highlighted included

- Right to information
- Right to choice of family planning method
- Right to reproduce
- Right to choose sexual partner
- Right to choose marriage partner
- Right to access services

4.4.13 CRPD

The United Nations Convention on the Rights of Persons with Disability (CRPD) was the ‘first comprehensive and legally binding international framework for psychosocial disability,’ (Drew et al. 2011:2) which provided a platform for analyzing barriers and enablers to inclusion of people with psychosocial disability within development policy and programming. The CRPD has specific provisions that recognize the reproductive rights of persons with disability (Art. 23); the right of people with disability to access SRH information and services (Art. 25); and the
specific need for empowerment of women with disability (Art. 6). In order for these rights to be achieved, women with disability need to be provided with age appropriate, accessible information on SRH, and to have recognition of their rights to have a sexual relationship, marry, establish a family, enjoy reproductive health, and physical integrity. However, several respondents had not even heard about the CRPD. One respondent had this to say,

“There is nothing happening about the CRPD; my office does not even have a copy”

Upholding the articles of the CRPD in an environment where the custodians of the domestication and eventual roll out of the CRPD do not even know about its existence will be an uphill task.

5.0 DISCUSSION

The perspectives and experiences of service providers described above reveal a range of barriers to SRH information and services for AGYW with psychosocial disabilities. Service providers highlighted the difficulties women and girls with psychosocial disabilities may face including paying for health services, articulating their needs to the service providers, dealing with the labels attached to them among others. These barriers have been well described in a range of settings and addressing these barriers underpins the Government and other organizations that are championing the cause of people with psychosocial disabilities. There still remains considerable work to be done to overcome these barriers to SRH for girls and women with psychosocial disabilities in Uganda.

Disability discrimination by health service providers is known to undermine the health of people with disability globally and addressing the discrimination faced by people with disability is another central element of organizations in the disability fraternity. However the findings of this base line survey highlights that the discriminatory attitudes towards girls and women with psychosocial disability held by some service providers, are often associated with limited understanding about
psychosocial disability and a lack of confidence in providing services for people with psychosocial disabilities. One respondent in the FGD said,

“I need to be told the truth, regardless of my current mental state; no one should reason for me; we need opportunity to speak for ourselves.”

This is a reflection of the fact that the people with psychosocial disabilities feel they are not being understood and their ability to reason is doubted by the service providers.

Some service providers were of the view that they offer services to the entire public without discrimination. This position is fronted as non-discriminatory and inclusive, but does not recognize the additional barriers women with psychosocial disabilities experience in accessing health services and that additional measures are therefore needed to increase equity of access.

Respondents faulted family and community on being culprits in promoting violence and abuse towards girls and women with psychosocial disabilities. Emphasis was laid on prevention of pregnancy arising from sexual abuse; without the consent of the affected individual. Parents were particularly held responsible for taking their daughters with psychosocial disabilities to family planning units to prevent pregnancy in the “likely” event of abuse. There is need to have a paradigm shift towards devising strategies to prevent the violence and abuse in the first place.

International agencies and human rights bodies have condemned the forced and coerced sterilization of women with disability as a gross violation of human rights. The practice has been documented around the world. While the challenges for women with disability and their families that arise from unwanted pregnancies, particularly in settings of poverty and over-stretched services are real, there is need to devise alternative strategies to prevent unwanted pregnancy including accessible sexual health education, less permanent forms of contraception, or by preventing sexual coercion and abuse.
Service provider education and capacity development is also required to improve the ability of health workers to understand and communicate effectively with people with psychosocial disabilities.

6.0 RECOMMENDATIONS

During the survey, the respondents provided feedback on what they thought would promote accessibility and uptake of SRH services for people with psychosocial disabilities. The following were some of the aspects mentioned

• There is need to do massive sensitization on the rights and needs of people with psychosocial disabilities. It is also important to create awareness on the CRPD because it is a guiding document for the rights of people with disabilities. The survey showed that the majority of the respondents except for those in the disability fraternity were ignorant about the existence of the CRPD and yet they are stakeholders in the domestication of the CRPD

• While society is aware about people with disabilities in general, there is still misinformation and ignorance about psychosocial disabilities. There is therefore need to demystify the concept of psychosocial disability so that society can understand it well. It was noted that even in the disability fraternity, people with psychosocial disabilities are relegated to the sidelines and in the process have even missed out on the support that targets persons with disabilities.

• More effort should be directed towards the establishment of new groups and strengthening of existing of peer support groups for people with psychosocial disabilities because they have proved to be credible platforms from which advocacy for people with psychosocial disabilities can be discharged from. Even stakeholders that would want to meaningfully engage with people with psychosocial disabilities will do so with ease when they know where to find them.

• There is dire need for protection of women and girls from sexual exploitation and harassment. This is one of the challenges that many women and girls with psychosocial disabilities are facing. There is also need to provide psychosocial
support and therapy for those who have been abused. This calls for networking with professional counselors

- Centers providing SRH services need capacity building support to enable them meaningfully engage people with psychosocial disabilities.

- There is need to establish a functional referral system so that all stakeholders know and appreciate the area of expertise of each stakeholder and do appropriate referrals. Triumph Uganda should have an office that is open to the public.

7.0 CONCLUSION

Efforts to sensitize health service providers to the experiences of PSDs have been demonstrated to increase disability inclusion in health services elsewhere. It therefore holds water that many SRH service providers in Jinja and beyond would benefit from disability sensitization to increase their awareness of factors undermining equity of access to services for girls and women with psychosocial disability. Awareness and sensitization training would support current service providers to use appropriate language when discussing disability, challenge misconceptions about sexuality and disability, and ultimately strengthen their capacity to provide better quality SRH services for AGYW with psychosocial disability. Strengthened engagement with organizations championing the cause of people with psychosocial disabilities would also increase service providers' understanding of the day-to-day challenges facing AGYW with psychosocial disabilities when trying to access SRH information and services.
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