A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal

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Abstract: Use of sexual and reproductive health (SRH) services is low amongst young people in Senegal. Although the evidence base on young people’s SRH needs is growing, research on access to SRH services amongst young people with disabilities is negligible. Our study explored the SRH vulnerabilities and expressed needs for young people with disabilities, experiences of accessing SRH services and what access challenges they face. Male and female peer researchers conducted 17 focus group discussions and 50 interviews with young women and men with disabilities between 18 and 24 years with a physical, visual or hearing impairment in Dakar, Thies and Kaolack in Senegal. Young people with disabilities reported very low knowledge about, and use of, SRH services including contraception and gynaecological consultations, but demonstrated a need for them, and were reliant on others to accompany them to service providers, impeding their access to confidential services. Multiple cases of rape were revealed, particularly amongst women with hearing impairments. Key barriers to SRH services were financial barriers, provider attitudes and accessibility (related to their disability). SRH policies and interventions for young people with disabilities should be based on an understanding of the intersection of youth, disability and gender. Urgent and targeted action is needed to improve provider attitudes and capacity to respond to the needs of young people with disabilities and to address the burden of sexual violence. DOI: 10.1080/09688080.2017.1329607

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Context
The exact proportion of the population living with disabilities in Senegal remains unknown; the World Health Survey in 2002–2004 reported it to be 15.5% but the more recent 2013 national census data estimates that 5.9% of the population in Senegal is living with a disability, approximately 800,000 people.2 People living with a disability are less likely to be employed and in education, experiencing higher poverty levels,1,3 exacerbating their financial barriers to healthcare and other basic services. Despite efforts to improve rights to education, health, employment and public services, people with disabilities in Senegal continue to face disproportionate disadvantages compared to the rest of the population: three out of four people with disabilities cannot read or write, health facilities and public buildings cannot physically accommodate them, and only 21% of those of working age have access to employment.4

Intersectionality is increasingly being used within public health research in lower and middle income countries. The approach helps us to explore the convergence of different social identifiers, types of exclusion and marginalisation within a population or an individual.5 Originally coined

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by Kimberlé Crenshaw in the USA in response to the exclusion of black women from feminist theory, the intersectionality framework is a useful starting-point for analysing the overlapping identities, external social expectations, vulnerabilities and means of accessing health services, such as those given by age, gender and a disability.

Intersectionality needs to be contextualised. The significance of multiple social categories (and their intersection) at the micro-level intersects with and must be understood in relation to macrolevel structural factors.

Only two studies (conducted in Zambia and South Africa) have been published that use intersectionality as a means of understanding how disability intersects with other social categories as a driver of sexual health in sub-Saharan Africa. The approach has not yet been applied to sexual health research, nor research on disability or young people, within a conservative West African setting such as Senegal.

Accessing SRH services is challenging for young people in Senegal. Studies on young people’s access to SRH information and services in Senegal, while limited in number, have revealed that knowledge about SRH issues remains very low. Only two studies (conducted in Zambia and South Africa) have been published that use intersectionality as a means of understanding how disability intersects with other social categories as a driver of sexual health in sub-Saharan Africa. The approach has not yet been applied to sexual health research, nor research on disability or young people, within a conservative West African setting such as Senegal.

Provider attitudes are also reported to have a detrimental effect on demand and access to SRH services, finding that resonates back to a paper from 2002. Older literature also highlights uncertainty over whether young people are legally allowed to access key SRH services. Senegal is also a deeply religious society, with over 96% of the population Muslim and 4% Christian, driving mostly conservative norms that stigmatise premarital sex. These norms are cited by young people as reasons not to access SRH services. Grey literature also implicates a role for financial barriers in limiting young people’s access to SRH services.

Young people with disabilities face other barriers to accessing these services, including stigma and discrimination related to their disability and misconceptions of not being sexually active. People with disabilities are frequently excluded from SRH services, often due to lack of adequate training of health staff, and SRH information not tailored to include appropriate content or in the necessary format (e.g. braille, sign language). Consequently, many young people with disabilities are reluctant to seek health care and have an unmet need for SRH services. Furthermore, the risk of sexual and gender-based violence is greater for people living with disabilities. A study from Ziguinchor, Senegal suggested that 9.3% of women and 3.4% of men with disabilities in Ziguinchor were coerced into sex during their first sexual encounter, but this may be underrepresenting the scale of the problem – global estimates suggest that 20% of women with disabilities are forced or coerced to have sex. The Senegalese Government ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2010, guaranteeing “that persons with disabilities … have access to sexual and reproductive health care (Article 25). A new initiative was launched in 2015 to enable subsidised healthcare services to people with disabilities through the use of an equal opportunity card (carte d’égalité des chances), with the Government committing to distributing 50,000 cards by 2017.

Our study objective was to understand what barriers and enablers young people with disabilities experience when accessing SRH services. Specific objectives were to explore: (1) the expressed needs and SRH vulnerabilities of young people with disabilities; and (2) their experiences of accessing SRH services, including the challenges faced in accessing these services.

We carried out this study in June and July 2015 in the context of a three-year multi-country programme named ASK (Access, Services, Knowledge) funded by the Dutch Ministry of Foreign Affairs.

Methods
We adopted a qualitative peer-to-peer approach to explore the sensitive nature of the research topic, with focus group discussions (FGDs) conducted first to gather information on overarching themes and general experiences young people with disabilities had in relation to sexuality, SRH and access to services and products. We invited 2 informants from each of the 17 focus groups to participate in an in-depth interview to explore their personal needs for, and experiences of their interaction with SRH information and services. In some research sites, if there were not at least six informants with a common disability and/or gender for a FGD, we invited people for an interview instead. This was the case for 16 interviews. Measures were taken to ensure that FGDs and interviews were organised in accessible locations, were conducted in sign language when necessary, and that visually impaired individuals were paired with non- visually impaired peer researchers to
effectively facilitate and note-take during FGDs. All data were collected in June and July 2015.

Study population and setting
The study population was young people aged 18–24 years, living with a physical or sensory (visual or hearing) impairment. The national research guidelines state that people under the age of 18 require parental consent to participate in the study. Given the sensitive nature of the study topic, young people under the age of 18 were not included. As per the CRPD, people with disabilities in this report are defined as those who have “long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

People with the following impairments were invited to participate in the study: (1) physical: limitation of the physical function of limbs, fine bones or gross motor ability; (2) hearing: partial or total hearing loss; and (3) visual: partial or total sight loss. Owing to the unique challenges — and experience required — of developing tools, sampling, obtaining ethical approval and extending the peer methodology, we did not include people with intellectual disabilities in the research.

We used purposive sampling to identify the informants for FGDs, from a sampling frame established in collaboration with associations working with people with disabilities in different regions of Senegal, including the National Association of Motor Disabilities, the Association of Women with Disabilities, the Association for the Blind, and the Association for the Deaf. After explaining the research objectives, confidentiality, anonymity and the right to withdraw from the study, all young people who were invited agreed to participate.

The total sample was 144 young people with disabilities, of which 128 participated in FGDs and 50 in interviews (34 of these were also FGD participants). A minimum of six and a maximum of eight informants were required to hold a FGD. Of the 17 FGDs conducted, 8 were with male informants, 7 with females, and 2 mixed, and out of the 17 FGDs, 5 groups were with young people with visual impairments, 5 with physical impairments and 7 with hearing impairments. Of the 50 in-depth interviews conducted, 46% (23) were with male informants (8 with hearing, 11 with visual, and 4 with physical impairments) and 54% (27) female (6 with hearing, 10 with visual, and 11 with physical impairments). Of the total 50 in-depth interviews conducted, 42% (21) had a visual impairment, 28% (16) a hearing impairment and 30% (13) a physical impairment. A summary of the number of FGDs and in-depth interviews by location, disability and gender can be found in Table 1.

We conducted the research in ASK project sites: Dakar, Thies and Kaolack. We selected Dakar as it has the largest concentration of health services and the largest representation of associations of people with disabilities, and Thies and Kaolack as these regions have important population densities in urban areas but vast rural areas with limited access to healthcare facilities.

Data collectors: recruitment and training of peer researchers
Peer approaches to qualitative research have become more popular in recent years, particularly in the study of SRH. We used a peer-to-peer approach whereby young people with disabilities were recruited and trained to collect and analyse qualitative data. We expected them to create a more comfortable and relevant environment for the study informants, given their shared experiences with the research subjects. We recruited and trained 14 peer researchers — 8 young men and 6 young women — of which 3 were visually impaired, 9 were living with a physical impairment, and 2 were sign language interpreters. One person dropped out prior to the start of the data collection phase. Most peer researchers were university students with the ability to speak French and Wolof and were computer literate. A journal article about the experience of working with peer researchers has been submitted.

To build the capacity of the peer researchers in qualitative research skills, we organised a four-day workshop following the EXPLORE toolkit — a toolkit developed by Rutgers and the International Planned Parenthood Foundation to train young people as researchers in sexual and reproductive health and rights (SRHR) programmes, to enhance youth participatory research techniques and to introduce them to the research topic and key concepts. After the data collection phase, we organised a 1.5 day workshop on qualitative data analysis and reflexivity.

The role of the principle investigators (authors EB and AlM) was to lead on all technical and administrative parts of the study, training of peer researchers and coordinate activities from conception through to dissemination. A Senegalese Research Supervisor (FK) was recruited to lead on
key aspects of the study including recruitment of peer researchers and supervision of data collection and analysis.

Data analysis

Qualitative data were transcribed by the peer researchers in French and transcripts were analysed by the research team using manual thematic analysis. Codes were identified for key concepts that represent recurring themes or noticeable anomalies. They were then organised around a pre-defined qualitative data analysis framework, to draw out key themes, as well as identifying emerging themes. During the 1.5 day analysis workshop in July 2015, the peer researchers were introduced to the basic principles of coding and analysis and made a start with analysing their data. While we intended the peer researchers to be meaningfully involved in the analysis phase of the research, we found that time constraints and the complexity of data analysis for inexperienced peer researchers negatively impacted the quality of the analysis. The principle investigator (EB) continued and finalised the data analysis on her own in order to guarantee quality and delivery within the available time and resources of the research project. The analysis compared and contrasted the themes amongst different disability and gender groups to find commonalities or divergences in the data. Transcripts were written in French and direct translation of any quotes was done by the Principal Investigator during data analysis.

Ethical considerations

Ethical approval was obtained from the local ethics committee, Comité National d’Éthique pour la

| Table 1. Focus group discussions and interviews by region, disability and gender |
|-------------------------------------------------|-----------------|-----------------|-----------------|----------|
| Region                                         | Dakar | Thies | Kaolack | Total |
| Focus group discussions (n = 128)               |       |       |        |        |
| N° conducted                                   | 11    | 5     | 1      | 17     |
| By disability                                  |       |       |        |        |
| 2 visual (1 male, 1 mixed)                     |       |       |        |        |
| 3 visual (1 female, 2 male)                    |       |       |        |        |
| 1 physical (1 female)                          |       |       |        |        |
| 5 hearing (2 male, 2 female, 1 mixed)          |       |       |        |        |
| 2 hearing (2 male)                             |       |       |        |        |
| 4 physical (3 female, 1 male)                  |       |       |        |        |
| By gender                                      |       |       |        |        |
| 5 female                                      |       |       |        |        |
| 1 female                                      |       |       |        |        |
| 1 female                                      |       |       |        |        |
| 4 male                                        |       |       |        |        |
| 4 male                                        |       |       |        |        |
| 2 mixed                                       |       |       |        |        |
| Interviews (n = 50)                            |       |       |        |        |
| N° conducted                                   | 30    | 15    | 5      | 50     |
| By disability                                  |       |       |        |        |
| 12 visual                                     |       |       |        |        |
| 6 visual                                      |       |       |        |        |
| 3 visual                                      |       |       |        |        |
| 10 hearing                                     |       |       |        |        |
| 4 hearing                                     |       |       |        |        |
| 2 physical                                     |       |       |        |        |
| 8 physical                                     |       |       |        |        |
| 5 physical                                     |       |       |        |        |
| By gender                                      |       |       |        |        |
| 20 female                                     |       |       |        |        |
| 5 female                                      |       |       |        |        |
| 2 female                                      |       |       |        |        |
| 10 male                                       |       |       |        |        |
| 10 male                                       |       |       |        |        |
| 3 male                                        |       |       |        |        |

*A total of 61 females and 67 males participated in the focus group discussions.*
Results

The main themes that emerged from the FGDs and interviews are grouped under categories outlined below. Some of the norms and challenges reported on by the informants may not be directly related to the respondents’ disability, and may be experienced by young people more generally. In the discussion, we analyse how these reported norms and challenges affect young people with disabilities more specifically.

SRH needs and vulnerabilities of young people with disabilities

Relationships and sexual activity

Sixty-six per cent (33/50) of interview informants (of which six women and two men were married) reported being in a relationship. The majority of informants reported having engaged in some form of sexual activity, including sexual intercourse, flirtations and petting. Forty-six per cent (23/50) of interview informants reported having had sexual intercourse (this excludes those whose only sexual experience was rape); with more men than women reporting onset of sexual activity (17 vs 6). Of the six women who reported having had sex (two with visual impairment, two with hearing impairment and two with physical impairment), five were married. Amongst the 17 men who reported having had sex (10 with visual impairments, 5 with visual impairments and 2 with physical impairments), only 2 were married. Marriage was considered an important factor linked to the onset of sexual activity, especially amongst women:

“The first man to be on me will be my husband, but never another.” (Female, 21, physical impairment)

Some informants opposed the perceptions that people have of them not being sexually active or able to have children because of their disability:

“I live with a disability but this is not an obstacle to having sexual relations and bearing children.” (Female, 25, hearing impairment)

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

Norms around sexuality and the use of contraception

Several men and women claimed their religion was against contraceptives and premarital sex, but young women more frequently than men demonstrated conservative and judgemental attitudes related to sex and contraceptive use outside of marriage, and these norms seem to be stricter for women than for men:

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

“A good person shouldn’t have sexual relations before marriage.” (Female, 22, physical impairment)

Other perceptions were evoked of how women with disabilities, in particular, are seen in society if they have sex outside of marriage:

“It’s rare for young women with disabilities to have sexual relations before marriage … to avoid negative judgement by the society in which we live.” (Female, 24, visual impairment)

Male informants were more comfortable talking about their own sexual experiences, including sex outside of marriage. Some expressed negative attitudes to women having sex and using contraception outside of marriage but overall this was less frequently pronounced than by women themselves. Other men focussed more on social norms related to how married women should not use contraceptives:

“I do not approve of married women using family planning.” (Male, focus group)

“When you are with your wife, you do not need to use family planning.” (Male, focus group)

Sexual violence

Experiences of rape and sexual violence were reported by five women (18% of all female interview informants), most commonly amongst women with hearing impairments, where four women (out of six in total) reported having been
raped once or multiple times, and one woman with a physical impairment. All rape incidences took place during adolescence or pre-adolescence. Perpetrators were often family members or family friends, and in one case a worker in a professional facility. Only one woman, with a physical impairment, reported seeking medical help following the rape. Women spoke of their fear to disclose these incidences, and the impact it has since had on them:

“I have never been in love. I was raped in 2008 by my uncle’s friend. Since then I have been distrustful … I have never had sexual relations apart from the rape … I am scared that I will be raped again. That’s the reason I don’t dare have a boyfriend.” (Female, 22, physical impairment)

Contraceptive knowledge and use
When young people with disabilities were asked what contraceptive methods they knew, most named at least three modern methods, of which condoms were consistently cited across all groups. A significantly lower knowledge of the range of methods was identified in the FGDs with young people with hearing impairments – only the condom was routinely named, and occasionally the pill. Some informants acknowledged the health benefits of contraception whilst misconceptions, such as sterility as a perceived consequence of contraceptive use, were common.

Whilst some informants reported always using a condom during sex, others – who had had sex – reported never having used one:

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

“I have never bought a product related to sex, but I was once shown a condom.” (Male, 20, visual impairment, who has had multiple sexual partners)

Amongst the 23 interview informants who had sex, 65% (15/23), of which only 2 were female and both were married, reported ever use of a contraceptive method and 35% (8/23) reported never use of contraception. One married man reported ever use of contraception, but information of use inside or outside of marriage was not obtained.

Sources of advice and information on SRH
Friends were the main confidants for relationship advice, for both male and female informants and across all disability groups. To a lesser extent family members were confidants; for female informants, female family members (especially sisters) were most frequently cited, but for male informants, family members were rarely cited. Nearly all informants said they would not confide in their parents. For male informants, the subject of sex and relationships was considered taboo, whilst for female informants, the subject was taboo but they also feared their parents’ reactions.

“In my family, we never talk about questions related to sexuality.” (Female, 20, hearing impairment)

Few other sources of advice or information were reported by young people with disabilities, with most stating an absence of knowledge of the existence of sources. A few male informants with visual impairments cited the radio as a source of information, whilst a few female focus group informants with physical impairments cited television debates and talk shows.

“The main problem remains the lack of information regarding the existence of such facilities.” (Male, 24, visual impairment)

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

Young people with disabilities’ experiences of accessing SRH services
Are young people with disabilities accessing SRH information and services?
The majority of young people with disabilities reported never having accessed SRH information or services, and across all disabilities and genders, young people with disabilities expressed a severe lack of knowledge of where to access such services:

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

Nine interview informants – 5 women and 4 men – (out of 50 interviewees) reported having ever accessed a service related to SRH, of which 2 women and all 4 men had had sex. Only one man and one woman were married, but all informants were in relationships, and those who accessed services had visual (four), hearing (two) and motor (two) impairments and lived either in
Dakar or Thies. The ages of informants varied from 19 to 24 years old, but the majority (seven) were over 22 years old but it must be noted that they were not asked to specify at what age they had accessed the SRH service(s). The remaining four who had never had sex but had used a SRH service did so for reasons related to menstruation or gynaecological infections. No informants reported using a carte d’égalité des chances to access services.

**Where are young people with disabilities currently accessing SRH information and services?**

The nine informants who did access SRH services – five female and four male – reported using their local public health centre or hospital, mainly due to their proximity to their house, a “Centre Ado” – a public centre that provides advice on SRH to young people – as well as private sector services such as NGOs, the Association of Women with Disabilities, or private pharmacies. Community health workers who primarily focus on women’s health (Badienou Gokh) were cited during several FGDs with women with physical impairments and in one FGD with women with visual impairments.

**What key factors determine the choice of where young people with disabilities would access SRH information and services?**

Study participants identified three main influential factors affecting where they would choose accessing SRH services: confidentiality, anonymity and proximity. Pharmacies were often cited as a potential source of SRH services or products due to their proximity, perceived quality and confidentiality, whilst local public hospitals for their proximity, and Info Ado (a phone line and SMS service) for its anonymity and convenience as travel is not required. Fear of being seen accessing a SRH service was apparent amongst several informants, and this risk was more commonly associated with frequenting the public sector;

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

**What barriers do young people with disabilities face in accessing SRH information services?**

Lack of confidentiality and anonymity, and distance were identified as key barriers to accessing SRH services, as well as provider attitudes and financial barriers. Other barriers cited were parents’ attitudes, physical accessibility and communication barriers (for those with hearing impairments). To a lesser extent marriage status, religion and lack of information about where to access SRH services were mentioned.

Female informants with visual impairments highlighted the issue of discrimination by health providers, using language to express degrading feelings related to their experiences such as “they make you feel your disability”, “they marginalise us” and “they neglect you because of your disability”. Male informants with visual impairments reported more internal barriers, such as having hang-ups (“complex”) about seeking SRH services. For those with hearing impairments, the communication barrier was particularly pronounced, with dependency on their family members to accompany them. Young people with physical impairments also faced physical barriers to accessing health centres, such as stairs in health centres that impede them from having easy access, or having to be accompanied by someone to facilitate access. If accompaniment is required, these young people with disabilities cannot access information or services in a confidential manner.

**Reliance on support networks**

Informants across all disability groups and genders reported a need to be accompanied by a family member or friend to access health services. Informants with physical impairments often had to ask a friend or family member to accompany them, and those with hearing impairments reported always needing accompaniment by a family member to a health centre, due to the communication barriers they experience. Some male informants said they were sexually active but had no one to talk to about it except for to their family:

“The fact of not being able to communicate with others causes enormous problems. I am obliged to be accompanied by my mother.” (Male, 24, hearing impairment)

**How would young people with disabilities suggest overcoming barriers to SRH information and services?**

Reducing financial barriers to services or providing free services were predominantly suggested by study participants, but other suggestions included: having young female providers to provide SRH services for young women; having health providers...
who can communicate effectively with people with hearing impairments; improving accessibility to health centres for people with disabilities (ramps, audio information); creating health centres or having specialist doctors specifically for people with disabilities; ensuring access to information on where services can be accessed and what contraceptive methods are suitable for people with disabilities and increasing awareness of SRH amongst parents.

Where would young people with disabilities prefer to access SRH information and services? Informants were asked whether they would prefer to access SRH services through the public or private sector. Responses were divided across genders and disability groups, but some clear trends emerged: private sector providers were largely considered of higher quality in terms of treatment and client care than public sector providers but public sector providers were perceived as more affordable.

Discussion
This study highlights that young people with disabilities need access to SRH information and services but today face challenges in accessing them. Many young people with disabilities in our study were in relationships and/or were sexually active, contradicting preconceptions that people with disabilities in Kwazulu-Natal are not sexually active, but they do not always have the necessary knowledge, ability or resources to access confidential SRH services.

Our study highlights the importance of analysing the social identities that intersect with culture as well as access to resources in health systems and broader support for young people with disabilities. Age, disability and gender are interlocked and affect young people with disabilities’ access to SRH services. Recognising the intersecting nature of gender, youth and disability, helps us to appreciate the specific vulnerabilities faced by young people with disabilities. Sexual violence emerged as a major vulnerability during the data collection. Our study confirms that people with disabilities are at risk of sexual violence. Vulnerability was most acute amongst females with hearing impairments, and during adolescence, yet they did not have access to health or social care, nor legal support mechanisms to mitigate the risks of sexual abuse. Due to the sensitive nature of the topic, the peer researchers did not feel comfortable to probe for perceived reasons for the rape or what made the informants more vulnerable according to themselves. Our study highlights the need for further research on sexual violence among young people with disabilities and to investigate the prevalence, not only by age but also by considering the specific and traumatic vulnerabilities of specific sub-groups of young people with disabilities.

Our study found that young people with disabilities face some similar barriers to those reported by young people living without disabilities in Senegal, that is, financial barriers and provider attitudes. Interestingly, provider attitudes were cited as one of the main barriers to access, yet only nine informants had ever visited a SRH service delivery point, so this barrier may not be based only on experiences, but also on perceptions. These are compounded by the restricting social and gender norms (especially regarding behavioural expectations for women) and lack of access to information about where they can access SRH services. The low utilisation of contraception is also reinforced by norms related to gender roles and sexuality, extramarital sex, and the use of contraception inside and outside of marriage. In fact, we found young people with disabilities focused more on barriers and challenges related to being young than on living with a disability, much like Chappell found in his research on love, relationships and sexuality amongst young people with disabilities in Kwazulu-Natal.

However, disability-specific barriers were identified particularly in relation to challenges accessing services. We heard stories of challenges for those with physical disabilities affecting mobility in health facilities that impede physical access, as well as limitations in the ability of health workers to communicate effectively with people with a hearing disability during a consultation. Dependence on others to be accompanied to a health service shapes young people with disabilities’ ability to access services confidentially and anonymously. Young people with disabilities are especially dependent on family members to accompany them, but with whom young people with disabilities also reported being unable to discuss issues around sexuality due to taboo or fear. Provider attitudes need to be addressed to recognise the sexuality of young people with disabilities as well as providing confidentiality in consultations when their support networks (especially family members) play a key role in helping young people with disabilities gain access to health services.
The current policy for equal opportunities for people with disabilities is not working. The negligible mention of the carte d’égalité des chances by study informants highlights that this card has not been made available to young people with disabilities or has had no impact on their access to health services. For young people with disabilities to access the cards, appropriate distribution mechanisms are required, but the quality of redeemable services must also be considered; if services are not youth and disability friendly, then uptake is likely to remain low. Policies must reflect the acute vulnerabilities which young people with disabilities face, and their specific needs must be considered in future efforts in order to uphold the commitments to protecting the SRH rights of young people and those living with disabilities.

Limitations
Both a strength and limitation of the study was the use of peer researchers. Their lived experience and ability to create rapport more easily with the study informants had a positive effect on the quality of data collected, enabling a deeper understanding of the study population’s experiences and needs. However, the peer researchers were not professional researchers and there were limitations to the depth that some themes were explored. Our study was a wide-ranging exploration of the SRH of young people with disabilities and did not examine each sub-theme in extensive depth, nor analyse findings by additional factors such as marital status, education level, employment status or religion. This limited the depth to which we could explore topics, trends and comparisons between groups within our study population and provides an opportunity to focus future research on specific themes and look at more socio-economic factors of the informants. The study did not, unfortunately, include young people with disabilities under the age of 18 years, nor young people with intellectual and mental disabilities. Specific questions about sexual violence were not included in the topic guides but due to the number of cases revealed in our study, exploration of this topic is recommended in future research as these data are not available. Our study did not aim to tease out the difference between young people and young people with disabilities as our informants were only from the latter group, so we can only speculate and compare to the (limited) existing literature.

Programmatic and policy recommendations
For the successful delivery of SRH information and services to young people with disabilities, policies and interventions need to be based on evidence and an understanding of the intersectional nature of disability, age and gender. Following our research, we suggest the following urgent programmatic and policy recommendations, as well as consideration of the full inclusion framework outlined in the UN/WHO guidance note on Promoting SRH for Persons with Disabilities:18

- Increase the evidence base of young people with disabilities’ vulnerabilities and needs:
  - Based on the findings of high levels of sexual violence, especially amongst young women with hearing impairments, and the lack of national data available, invest urgently in researching the burden of rape, and other forms of sexual abuse, experienced (by disability and by age).
  - In line with the principle of “nothing about us, without us”, include young people with disabilities in the development of SRH policies and programmes as these are the most informative and appropriate resources to inform policies and programmes.
  - Due to the absence of literature or studies on the SRH of young people with disabilities in Senegal, and the wider sub-region, increase research, and thus data, on the SRH of young people with disabilities to enable policy makers and stakeholders to develop targeted policies and interventions. A new UNFPA initiative, WE DECIDE, has launched a global study on the SRHR of young people with disabilities,20 providing an opportunity to collect national data and feed into global analysis.

- Ensure adequate response mechanisms are in place to respond to sexual violence amongst young people with disabilities
  - To respond to the needs of those who have been raped or subjected to other forms of sexual abuse, quickly develop or adapt response mechanisms (medical, legal and social), such as creating an informed and responsive environment for young people with disabilities to feel able to report rapes, and other forms of sexual abuse (including sensitisation of the police, lawyers and community leaders and members).
○ Ensure mechanisms are in place, and known to young people with disabilities, to provide support such as confidential phone lines, peer support networks or the appropriate medical services, to young people with disabilities.

- Increase access to SRH information and services for young people with disabilities:
  ○ As young people with disabilities do not know where to access SRH information and services, increase access to information about SRH services in an accessible format for young people with disabilities, including bringing information to where young people can be reached (e.g. through outreach work, or through peer networks).
  ○ To ensure confidentiality for young people with disabilities in accessing SRH information and services without being accompanied by a friend or family member, create a more enabling environment for this to happen. For example, replicate some of the existing innovative approaches, for example, such as those by LVCT providing VCT services to deaf people and training SRH providers in basic sign language.29
  ○ Where strategies for reaching young people already exist, adopt these strategies to include and target young people with disabilities (e.g. via community health workers or SMS and telephone helplines).
  ○ Our study revealed that cultural norms can influence young people with disabilities’ access to SRH information and services, such as norms related to sex outside of marriage and how young people with disabilities fear being seen accessing a SRH service. Creating a more enabling environment for young people with disabilities to discuss their SRH openly and access SRH information and services by engaging their support networks and community mobilisation, and/or creating a safe space for young people with disabilities to access these services (such as youth centres/clinics) is therefore required.
  ○ As many study participants said that one of their main barriers to access SRH services was financial, financial or voucher schemes should be introduced for young people with disabilities to access free or subsidised SRH services, including ensuring access to the cartes d’égalité des chances.
  ○ As another main barrier identified by young people with disabilities was the fear of provider attitudes, increasing the capacity of service providers to understand the needs and vulnerabilities of young people with disabilities is crucial, including the provision of training, tools, materials and referral mechanisms with the social and legal system.
  ○ As young people with disabilities face barriers to physically accessing current service delivery points, it is essential that these are adapted to respond to the physical needs of people with disabilities.

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Au Sénégal, les jeunes utilisent peu les services de santé sexuelle et reproductive (SSR). Même si les données sur les besoins de la SSR des jeunes se multiplient, la recherche sur l’accès aux services de SSR chez les jeunes vivant avec un handicap est négligeable. Notre étude a exploré les vulnérabilités et les besoins exprimés en matière de SSR des jeunes vivant avec un handicap, leurs expériences et les obstacles qu’ils rencontrent dans l’accès aux services de SSR. Des chercheurs pairs masculins et féminins ont animé 17 discussions de groupes d’intérêt et 50 entretiens ont été menés avec de jeunes femmes et hommes âgés de 18 à 24 ans vivant avec un handicap physique, visuel ou auditif à Dakar, Thiès et Kaolack au Sénégal. Les jeunes vivant avec un handicap ont fait état de très faibles connaissances sur la SSR et d’un recours peu important aux services de SSR, y compris les consultations de contraception et gynécologie. Ils ont néanmoins montré qu’ils en avaient besoin et qu’ils compartaient sur d’autres pour les accompagner auprès des prestataires de services, ce qui empêche l’accès aux services confidentiels. De multiples cas de viol ont été révélés, particulièrement chez les femmes ayant un handicap auditif. Les principaux obstacles aux services de SSR étaient les barrières financières, les attitudes des prestataires et l’accessibilité (relative à leur handicap). Les politiques et interventions de SSR pour les jeunes vivant avec un handicap devraient être fondées sur une compréhension de l’intersection de la jeunesse, du handicap et du genre. Une action urgente et ciblée est nécessaire pour améliorer les attitudes des prestataires ainsi que leur capacité à répondre aux besoins des jeunes vivant avec un handicap et à s’attaquer au fardeau de la violence sexuelle.