Access to and Utilization of Reproductive Health Services by Women with Disabilities in Rural Uganda

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1.0 Background

The health situation of women in Africa is generally poor especially when it comes to issues of maternal and child healthcare. This situation is even worse among rural women with disabilities who are unable themselves, but at the same time are pregnant and need antenatal care services and other RH services. The World Bank (1994) reported a reduction in the number of infant deaths over the past 30 years. However, the number of women who die from pregnancy and birth is still high. Given the above picture, however, every minute, one woman dies from a problem related to pregnancy and every minute, 30 women develop a lasting health problem related to pregnancy. This means that after sometime, about 1/4 of all women will be seriously affected by complications from pregnancy and birth.

The overall health situation in Uganda is characteristic of a country suffering from structural imbalance and poverty. Access to RH services and information is generally inadequate for the entire population. It is believed that access is poorer for People With Disabilities (PWDs), who prefer services of traditional healers to those of health institutions, due to unfavorable attitudes

surrounding their image in addition to the costs involved. Each year, pregnancy and childbirth claims the lives of over 6,000 women and approximately 120,000 newborns in Uganda (SUPRE 2005). The highest burden is born by rural women with disabilities who have long distances to cover from their households to the referral hospitals when they develop life threatening pregnancy related complications.

However, in any given situation, utilization of RH services is a complex interaction between the availability of services, including the terms on which they are available, the health status of the population and their health habits; that is, the propensity of seeking care of that particular society (Kyamanywa, 1994).

1.1 Statement of the Problem

The extent of access to and utilisation of reproductive health services by rural women with disabilities is not clear. There is lack of systematic, accurate data on the exact extent and nature of disability in Uganda. A related study was carried out in Mbarara Municipality (Kisembo, 2001), but it is not known with any degree of accuracy what RH problems Rural Women With Disabilities (RWWDs) face and specially designed programmes to cater for their RH needs. It is not known whether there are variations in access to and utilisation of RH services by women with different types of disabilities. Efforts geared towards improving access to and utilisation of RH services by RWWDs if any, are not known and it is not known whether RWWDs in Kabale district are knowledgeable about their RH, and the programmes in place, which provide RH information and services.

1.2.0 General Objective

To investigate the access to and utilisation of Reproductive Health services by rural women with disabilities in Rural Uganda.

1.2.1 Specific Objectives

1. To explore the extent to which socio-cultural, demographic and economic factors influence access and use of RH services among RWWDs.

2. To find out the rural women with disabilities' level of knowledge and utilisation of RH services.

1.3.0 Methodology

1.3.1 Area of study and study population

The study was carried out in rural Kabale district in South Western Uganda. The 2002 UPHC records the population of Kabale as 458,318 people, with 14,295 (3.12%) of its population with disabilities. The district is hilly with some of the areas very remote. Kabale district is poorly served with health facilities, with 1 hospital, 5 HC IVs, 14 HC IIIs, 47 HC IIs and 56 parishes having no health unit at all (http://www.health.go.ug/inventory.htm). The interest in this area was developed after realizing the difficulties of women with disabilities in accessing health care services and noting the unfavourable terrain, especially to the poor rural women with disabilities. In the study, two counties of Rubanda and Ndorwa were selected. Out of every county, five sub-counties were selected for the study.

1.3.2 Research design

The study was cross-sectional in nature, employing both qualitative and quantitative methods. It was focused on rural women with moving difficulty, seeing difficulty, hearing/speech difficulty or learning difficulty. Females of the reproductive age 13-49 were interviewed in relation to accessibility and utilization of reproductive health services particularly, among them antenatal care services, EmOC, delivery, post natal care, post abortion care and family planning services. The reason for using the reproductive age 13-49 instead of 15-49 is that many young girls with disabilities do not go to school, and many of them marry off early or are taken advantage of by men. A baseline report by PEARL (2003) in Nebbi district reported early initiation of adolescents into sexual activity due to poverty and school drop out. Action on Disability and Development: Evaluation of the Uganda Country

Programme 1997-2000 reported a large number of single mothers. For example, deaf women in Dokolo district complained about sexual abuse leading to unwanted pregnancies. Respondents were selected irrespective of their socio-economic and cultural background, religion, and the status in the area.

1.3.3 Variable selection

Seven independent variables were used in the study. These are; age, marital status, occupation, distance from the health facility, type of disability, education, and number of children. Intermediate variables included available services, choice of the means of access and nature of information available. The dependent variable was access to and utilisation of RH services.

1.3.4 Sample selection

The study area is divided into 3 counties, Rubanda, Rukiga and Ndorwa. Two counties of Rubanda and Ndorwa were used for this study. The study sample was selected using the Leslie Kish sampling formula (Kish, 1965).

n = …… (i)

Where; n is the desired sample size

Z is the standard normal value corresponding to the required level of confidence (95%) = 1.96

p is the proportion of RWWDs accessing and utilising RH services, assumed to be 50%

q = (1.0-p), is the proportion of RWWDs not accessing and utilising RH services

d is the desired precision of the estimate 5% (0.05)

$$n = \frac{1.96*1.96*0.5*0.5}{0.05*0.05} = 384$$

Population of women in the selected sub counties of Ndorwa and Rubanda 124163

Women of child bearing age (15-49) 22.4%

Disability in Kabale district 3.12%

Table 1 Nature of disability by percentage in Kabale district.

Nature of disability	Percentage
Limbs	35.3
Hearing/speech	19.0
Sight	5.7
Mental retardation	3.6
Others	36.4
Total	100

Source: 2002 UPHC

But the study was based on the four types of disability: limbs, hearing/speech, sight and mental retardation.

Women of reproductive age (15-49) = = 27813

Women (15-49) with disabilities =3.12% * 27813 =868

Nature of disability

Limbs =306

Hearing/speech =165

Sight = 58

Mental retardation = 31

Total = 560

Applying the finite population correction factor,

$$Fpc = \sqrt{\quad}$$

$$= \sqrt{\quad} = 0.56111$$

$$= 0.56111 * 384 = 215.466$$

The study is however based on findings from 187 rural women with disabilities and 10 key informants because it was very hard to get the 215 rural women with either of the following disabilities; moving difficulty, seeing difficulty, hearing/speech difficulty and learning difficulty. The researcher used a checklist of names of women with disabilities in Kabale district got from the district focal person for people with disabilities to select respondents and to locate them.

2.0 Access to and Utilisation of Reproductive Health Services.

Table 2: Socio-economic Characteristics of Respondents

	Frequency	**Percentage**
Marital status		
Single	34	18.2
Married	111	59.3
Others	42	22.5
Total	**187**	**100**
Education level		
None	99	52.9
Primary	69	37.0
Secondary	19	10.1
Total	**187**	**100**
Nature of disability		

Moving difficulty	160	85.6
Others	27	14.4
Total	**187**	**100**
Availability of health facility		
Yes	184	98.3
No	3	1.7
Total	**187**	**100**
Distance to nearest health facility		
1km-3km	74	39.6
3km+	113	60.4
Total	**187**	**100**
Occupation		
Farming	22	11.8
Handcraft	57	30.4
None	108	57.8
Total	**187**	**100**

3.0 Determinants of Utilisation of Reproductive Services

Table 3: Logistic Regression Results for Utilisation of Delivery Services

Variable	**Odds ratio**	**Std. Err.**	**p-value**	**95% CI**
Occupation				
*Agriculture	1.000			
Handcraft	3.854	3.142	0.098	0.7802-19.043
Housewife	3.647	2.172	0.042	0.937-15.796
Marital status				
*Single	1.000			
Married	3.330	1.885	0.034	1.097-10.102
Distance				
*Less than 3km	1.000			
3km+	2.596	1.382	0.043	0.914 -7.372
Knowledge				
*Friends as source of information	1.000			

Relative as source of information	2.998	1.488	0.027	1.134 - 7.930

* Reference categories

Delivery services and no occupation at all

Rural women with disabilities who had no occupation at all had 3.6-fold increased odds of utilising delivery services (p=0.042). The study revealed that there was no statistical significance between having no occupation at all and delivering from a health facility. This is because there were a number of factors determining the place of delivery, including income of the woman, distance to the nearest health facility, terrain and support from the relatives or family members. This is in agreement with Magadi who found out that delivery was determined by a wide range of factors, socio-economic and cultural factors associated with individual woman or her household, reproductive health behaviour relating to a specific birth, as well as availability of and accessibility of health services within the community (Magadi, et al, 2000). Bringing services closer to the rural women with disabilities in Kabale district would go a long way in improving their utilization of delivery services.

Utilisation of Delivery Services and Marital Status

Married rural women with disabilities in Rubanda and Ndorwa counties of Kabale district had 3.3-fold increased odds of utilising delivery services (p=0.034). This shows that there is a strong correlation between being married and delivering from the health facilities. Rural women with disabilities confessed that when a woman is married, she is not stigmatized when she becomes pregnant and this gives her courage to go to the health facilities for treatment and delivery. They agreed that being married goes with some responsibility on behalf of the husband and he can offer support in terms of the money needed for health services, including delivery. Besides, being married offers one a chance of being cared for by the husband who wants the wife to produce. This is because children are highly valued in rural areas of Kabale district. This is in agreement with Magadi's findings among Kenyan women who found that the desirability of the pregnancy was an important factor

in seeking of health services by the mothers (Magadi et al, 2000). Because many single mothers confessed that many men want them for sex and don't want to identify with them or even marry them, there is need for strict laws in favour of rural women with disabilities.

Utilisation of Delivery Services and Distance

Rural women with disabilities living in 3km+ radius from the nearest health facility had a 2.6- fold increased odds of delivering from the health facility (p=0.043). This shows that there is a significant relationship between distance and utilisation of delivery services. Rural women with disabilities believed that those who lived more than 5km from the health facility were likely not to seek delivery from the health facilities. The problem of distance is complicated by poor terrain, nature of disability and lack of moving appliances which makes access to health facilities rather difficult. More so, the health facilities are ill equipped, the medical personnel don't like rural areas and services offered are limited, for example, surgery, x-ray and specialized care services are offered in Kabale regional referral hospital, which is many kilometers away from the rural areas. Many rural women with disabilities had to travel long distances for such services. This is the same as Ayiga's findings in his study of Infant and Childhood Mortality Dynamics (Ayiga, 1999). When ill or seeking preventive services, the rural women with disabilities must walk to the health facilities since public transport in rural areas is limited. It may take a pregnant woman with disabilities 4 hours to walk a distance of 6km to the health facility. This factor may influence the decision of some mothers to seek care, especially ANC and delivery assistance services as noted by UNICEF (UNICEF, 1989). There is need to bring services closer to the rural women with disabilities.

Utilisation of Delivery Services and Source of Knowledge

Rural women with disabilities who used their relatives as a source of information had a 3- fold increased odds of delivering from the health facility (p=0.027). This shows that getting information from a relative is significantly related with delivering from the health facilities. This is because of the support that goes with information from the relatives. Rural women with disabilities confessed that their relatives were near them and supportive through pregnancy.

They are willing to provide food, money and every advice and even accompany these women to the health facility for delivery. Data from the ground reveals that the most commonly used channel in the dissemination of reproductive health information is the radio (70%) and the most common problem faced in accessing RH information is lack of money (30%). There is need for encouraging relatives of women with disabilities, who can afford to buy radios to be closer to them and sensitization of the community against stigma against rural women with disabilities. Improving the economic status of rural women with disabilities would also make it easy for them to access the information and utilise the reproductive health services.

Table 4: Logistic Regression Results for Utilisation of Family Planning

Variable	Odds ratio	Std Err	P- value	95% CI
Age				
*20 and below	1.000			
21 and above	1.088	0.455	0.044	1.002 - 1.181
Education level				
*None	1.000			
Secondary+	6.249	5.821	0.049	1.007-38.789
Source of knowledge				
*Friends	1.000			
Health workers	5.767	3.956	0.011	1.503 -22.125

* Reference categories

Utilisation of Family Planning Services and Age

The study revealed that older women with disabilities in the counties of Ndorwa and Rubanda of Kabale district had 1.09 times increased odds of utilising family planning services (p=0.044). Though it is widely believed that women with disabilities are neither sexually active nor capable for child bearing, majority of them are both sexually active and capable of pregnancy and childbirth and thus have reproductive health needs, including family planning. Men were taking advantage of rural women with

disabilities at an early age, and because of the stigma that goes with their nature of disability, many women were not seeking family planning services. There are no family planning services tailored for the young women and the providers don't expect young women to seek family planning services. This is in agreement with what Becker found out that providers sometimes appeared surprised that women with disabilities would be sexually active and did not ask about contraceptive use or assess for sexually transmitted diseases (Becker, et al, 1997). The situation becomes worse for the young girls who become pregnant. The study revealed that age is a significant factor in the utilisation of family planning because effective contraceptive use is determined by access to health care and financial issues. This is because the most effective forms of contraception are prescription products or surgical, people with poor access are less likely to use contraceptive methods with greater effectiveness. This is line with other findings by other researchers. Blane noted that many young women were not utilising family planning services because of the desire for more children, significant social barriers to the adoption of family planning at the household and community levels, communication problems between men and women and fear that use or even discussion of family planning may be interpreted as signs of unfaithfulness or lack of commitment to the marriage (Blane K.A, et al, 1996). The use of available services is affected by many factors including the Organisation of health services and belief systems (Kroeger 1983), accessibility to services (Fiedler 1981) and discrimination of care (Gapta 1987). Rural women with disabilities need to be educated and encouraged to delay marriage. Men need to be sensitized and to participate in the reproductive health of their wives.

Utilisation of Family Planning Services and Education

The study revealed that rural women with disabilities in Kabale district who had attained secondary education and above had 6 times increased odds of utilizing family planning services ($p=0.049$). This shows education is significant in seeking family planning services. This is in line with Fatma El-Zanaty's findings in an indepth study on the reasons for non-use of family planning in upper Egypt (Fatma El-Zanaty, et al, 1999). Low education led to insufficient information about family planning- specific methods and where to obtain them and lack of information. Ntozi, in his

study of high fertility in rural Uganda found out that knowledge increased with education (Ntozi, 1995). The study revealed that there is an unmet need of family planning on the part of rural women with disabilities in Kabale district concerning family planning. Many said they had the information about family planning but the quality of knowledge appears to be poor. Most women used inject plan as the only method of family planning and the reason given was that it was the only method offered to them. There is need for increased sensitization and education of the rural women with disabilities and offering them a wide choice of family planning methods.

Utilisation of Family Planning Services and Source of Knowledge

A number of studies show that the level of knowledge of family planning is high. Sources of knowledge included radios, relatives, health workers and newspapers. However, those utilising family planning are still few compared to those that confess to having heard about family planning. Rural women with disabilities' utilisation of family planning was hindered by many other factors, including the desire for more children, significant social barriers to the adoption of family planning at the household and community levels. Communication problems between men and women are significant social problems as well; fear that use or even discussion of family planning may be interpreted as signs of unfaithfulness or lack of commitment to the marriage (Blane et al, 1996).

Utilisation of Family Planning Services and Health workers as Source of Information

Rural women with disabilities who got information from the health workers had 5.8 times increased odds of utilizing the service ($p=0.011$). This shows a very strong correlation between using family planning and getting information from the health worker. This was attributed to the good relationship established between the women and some health workers, together with the trust these women have in the health workers. Majority women who don't use family planning do so because of poor terrain, long distance to the health facilities, and fear of stigma from the heath workers. The information on the ground revealed that the training of more health workers and bringing services closer to the women with disabilities

would go a long way in improving the reproductive health situation in rural Kabale.

4.0 Conclusions

Older rural women with disabilities utilised family planning and delivery services more than young rural women with disabilities. This is because of the stigma that attached to women with disabilities and especially when they become pregnant at an early age. As a result, those who become pregnant deliver out of the health facilities.

Health workers play a very important role in encouraging rural women with disabilities to use family planning and deliver from the health facilities. Majority of those who got RH information from health workers as a source of information utilised family planning services.

Education of rural women with disabilities had much influence on utilisation of family planning services. The study revealed that those with secondary and tertiary education were more likely to utilise family planning services than those with primary or no education at all.

The counties of Ndorwa and Rubanda in Kabale district generally fall below the accepted health standard. The health facilities in the area are few compared to the population they are supposed to serve. Access to private clinics cannot be guaranteed for a number of reasons including financial costs, and relative absence in the more rural areas where most of the currently underserved populations are based. In areas where health facilities exist, they are not favourable for the rural women with disabilities. Most health facilities had no provision for the wheel chairs and the beds were high that it was not easy for women with disabilities to climb them easily.

Majority rural women with disabilities give birth outside the health facilities. The study revealed that factors influencing this low

utilisation of RH services are: poor terrain, lack of money, level of health awareness and education, strong beliefs and confidence in traditional birth attendants, disagreements with husbands, long distance to health facilities, discrimination/stigma and dissatisfaction with the quality of health services. The issue of 24-hour coverage in most health facilities, with inadequate number of staff as a major contributory factor is important in addressing questions of access to and utilisation of reproductive health services.

Rural women with disabilities had a big problem with mobility. Most women are crippled and find it hard to move from their homes to the health facilities, given the fact that health facilities are located far away from their homes and the area is hilly. The study found out that nothing much was done to help these women with mobility appliances to ease their transport. The situation was compounded by lack of the facilities to the health facilities after the women have struggled to reach the health facility and the poor reception by the health personnel. At times, women with disabilities were discouraged by the long time spent waiting for the health personnel to provide services and the financial cost of the drugs, especially those not at the health facility.

5.0 Recommendation

The government and the concerned organisations should create awareness among rural women with disabilities and the local community. This helps inform the women with disabilities their reproductive health rights and where to get RH services. Awareness should be aimed at informing rural women with disabilities about the reproductive health services in place and where and when to get them. It should also be aimed at doing away with stigma attached to the nature of disability among the community members. This can help women with disabilities to break the negative social image and enable the service providers and the community to be more friendly to rural women with disabilities.

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