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KNOWLEDGE LEVEL ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS AMONG YOUTHS WITH DISABILITY IN SELECTED CENTRES OF KISII COUNTY, KENYA

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DECLARATION

This work is authentic, and it has not been presented for an award of a certificate, diploma or a degree in any other university.

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This thesis has been handed in for scrutiny with our consent as University supervisors

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DEDICATION

I commit this thesis to my kin: Geoffrey my husband for his back up and exhortation, my daughter Meryl and sons Mizzah and Manuel for their forbearance during my period of study. My mom Pacifica who attested to my going to school, and also for her inclined spirit that kept on revitalising my strength. Finally to my brother Michael and sister Marystella for assisting my children during my non presence, their prayers and motivational words.

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ABBREVIATIONS AND ACRONYMS

AIDS -Acquired Immune Deficiency Syndrome

ANOVA - Analysis of Variance

APDK -Association of the Physically Handicapped in Kenya

CEDAW -Convention on the Elimination of all Discrimination against Women

DRC -Disability Rights Convention

EARC - Educational Assessment and Resource Centre

GBV -Gender Based Violence

GOK -Government of Kenya

GMR -Global Monitoring Report

HIV -Human Immunodeficiency Virus

ILO -International Labour Relations

ICF -international classification of functioning of health

KNBS - Kenya National Bureau of Statistics

KSS - Kisii Special School

KDHS -Kenya Demographic and Health Survey

KAP -Knowledge Attitude and Practices

MOH -Ministry of Health

PLWHA -People Living With HIV and Aids

PWD -People With disability

PWPDs -People with Physical Disabilities

RH -Reproductive Health

SDG -Sustainable Development Goals

SMD -Social Model of Disability

SRH -Sexual and Reproductive Health

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SRHR -Sexual and Reproductive Health Rights

STI -Sexually Transmitted Infections

UNCRPD -United Nations Convention on the Rights of Persons with Disability

UNESCO -United Nations Educational, Scientific and Cultural Organization

UDPK -United Disabled Persons of Kenya

UNFPA -United Nation Population Fund

UNICEF -United Nations Children Funds

UPIAS -Union of the Physically Impaired against Segregation

WHO -World Health Organisation

WWD -Women with Disability

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DEFINITION OF OPERATIONAL TERMS

Disability/Impairment:	Movement limitation caused by a coexistent way of life and excludes them from participating in the mainstream of social activities.
Persons with disability:	Persons with physical, mental, and hearing impairment
Reproductive health:	A status of total bodily, mental and social welfare, and not simply the non-presence of a malady.
Structural factors:	Those that hinder normal operations among the youth with disability
Violation:	Not complying**.**
Youth:	Individuals who are between 15 and 24 years as per the WHO.

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ABSTRACT

Youth with disability often face obstacles and challenges in regards to exploring and exploiting their potential as sexual beings. This in turn deprives them of their human rights comprising of their sexual and reproductive health rights and may internalize various sexual assumptions and attitudes regarding their sexuality. The intent of this study was therefore to assess the level of knowledge on sexual and reproductive health rights among youths living with disability in selected disability centres in Kisii County, Kenya. The study specifically focused on socio-demographics, awareness and health system characteristics associated with level of knowledge on reproductive health rights. The study embraced a cross-section descriptive study design employing both the quantitative and qualitative data collection methods. The study aimed at a representation of 130 respondents who were randomly extracted from the study population using folded pieces of paper. The respondents selected were proportional to the number of youths with disability in Gianchere Special School, Kisii Special School and Association for the Physically Disabled in Kenya, Kisii branch. All necessary ethical and logistical considerations were sought from relevant authorities before the study was conducted. Quantitative data was gathered using structured questionnaires given to respondents through well trained research assistants. Qualitative data was collected using key informant schedules and focused group discussion guides. Statistical Package for Social Sciences version 22.0 was used in analyzing quantitative data. Descriptive statistics were used to present quantitative data in form of frequency tables, percentages, pie charts, and bar graphs. Qualitative data from focused group discussion sessions and key informants were triangulated with quantitative data as direct quotes or narrations from respondents. Inferential statistics were computed using Chi Square tests to establish the association between study variables at 95% confidence interval ($p<0.05$). The results revealed that 55.9% of respondents had low knowledge level towards reproductive health rights. It was revealed that 59.1% of youths living with disability in Kisii County were conscious of their sexual and reproductive health rights. Awareness ($p=0.012$) and number of reproductive health rights mentioned ($p=0.018$) were significantly associated with level of knowledge on sexual and reproductive health rights. Majority of socio-demographic factors such as marital status ($p=0.001$), degree of disability ($p=0.001$), having children ($p=0.001$), type of education involved in ($p=0.030$), breadwinner ($p=0.001$) and breadwinners' occupation ($p=0.001$) were significantly associated with level of knowledge on reproductive health rights. Majority of health system factors such as attitude of healthcare providers ($p=0.001$), provision of information ($p=0.012$), unfriendly physical infrastructure ($p=0.001$), disability being a hindrance and ever utilized sexual and reproductive health services ($p=0.019$) were significantly associated with level of knowledge on reproductive health rights. The study concludes that there were low knowledge levels despite high level of awareness towards reproductive health rights among youths with disability in Kisii County. These findings would inform policy on reproductive health issues thus increase knowledge and awareness levels consequently improving the rates of utilizing reproductive health services among youths with disability. This provides room for adoption of appropriate strategies to ensure sexual and reproductive health rights among youths with impairment are protected.

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CHAPTER ONE: INTRODUCTION

1.1 Background

Disability refers to inefficiency, activity and participation restrictions between a person with a health condition, person, and an environment (ICF, 2016). Disability is a part of human and nearly everyone might for some time grapple with a disability. It is estimated that 15% of the world populace is exposed to some form of impairment in life (UNFPA, 2016). Globally, approximately180 to 200 million individuals with impairment are between 10 and 24 years of age (UNFPA, 2018). Youth with disabilities have been identified as a minority group and insignificant of all the human race youth (Groce *et al,* 2013).

Sexual health entails figuring out threats, obligations, consequences and impacts of sexual deeds and practice of abstinence. It is a condition of physical, passionate, mental and social prosperity comparable to sexuality (ICF, 2016). Sexual rights incorporate the privilege to reasonableness and not being victimized; the option to be at freedom from torment or cruel, unfeeling or disparaging control or discipline; the privilege to privacy; the privilege to the most elevated feasible norm of wellbeing; the option to participate in marriage; the option to decide the number and separating of one's youngsters; the privilege to realities and preparing; the privilege to autonomy of judgment and profession; and the privilege to a viable solution for infringement of fundamental rights (WHO, 2015b).

States Parties in the Disability Rights Convention are compelled to protect persons with impairment from manipulation, brutality and abuse. The ‘Vienna Declaration’ and the ‘Programme of Action’ reaffirms that the impaired are equally legible to all human rights (McKee *et al*, 2016). Sixty per cent (60%) of ‘unfit’ women were forcefully sterilised in America, this was in order to abolish bad genes and regulate population as the Eugenic

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law dictated. Those termed ‘unfit’ included but not limited to women who were mentally and physically handicapped (Lawrence, 2018).

A research done in India among women with impairment revealed that a small proportion of the sample studied had been forcefully sterilised. The United Nations CEDAW gave a proportion of majority of disabled Indian women being victims of sexual violence whereas parents and caregivers consented for hysterectomies on most disabled girls (Changoiwala, 2014). A study on exploration of barriers and enabling factors for YPWD to access SRH services in Senegal, displayed that majority of the participants were in a relationship, most of whom had had a sexual experience, and approximately half of the participants had engaged in sexual intercourse (Burke *et al*, 2016). In Burkina Faso YWD are prone to violence and neglect than the non-disabled population. YWD are three times more likely to be exposed to physical, sexual and emotional violence (UNFPA, 2016).

A Kenyan study on visually impaired adolescents revealed a quarter of the respondents aged 15-19 years had peers with whom they were having coitus, this was much more elaborate for girls than boys. This reveals that most girls with visual impairment are sexually active, (Kyalo, 2010). PWD represent 3.5% of the total Kenyan population (KNBS, 2009). Former Nyanza province is ranked with the highest proportion (5.6%) of PWD (KNBS, 2009) and the prevalence of YWD aged 15-24 is 21% (KNSPWD, 2013). There being a dearth of information on SRHR among YWD, there is need to investigate on this issue.

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1.2 Statement of the Problem

YWD like their non-disabled counterparts deserve equal treatment of human rights including the SRHR. This can be achieved through channels for creating awareness and imparting knowledge on the YWD. But the opposite regarding YWDs is that they are still facing challenges exercising their basic rights and their full approval in society is wanting (Lord *et al*, 2012). Respect for SRHR of the disabled people as entrenched in the Convention on the Rights of persons with Disability (CRPD) help promote good SRH and gaining access to universal health (CRPD, 2014). SRHRs also promotes equal rights to marriage, having a family and personal relationships, promotes ability to make decisions on how many children to sire and when, and it prohibits sterilisation against individual will (CRPD, 2014). SRHR promotes family planning and access to other SRH information that is vital in decision making regarding sexuality (CRPD, 2014).

The Kenyan government has put various efforts in position to safeguard the rights of youths with impairment. Kenya as a signatory to the UNCRPD seeks to promote a broad and impartial appreciation of human rights in totality including SRHR and basic freedoms and to encourage reverence for their immanent worthiness (CRPD, 2014). Kenya enacted 'The Persons with Disabilities Act' of 2003 grants for the rights and reformation of PWDs in order to bring about equalization of favourable circumstances. United Disabled Persons of Kenya (UDPK) is mandated to ensure PWD share an equal platform and enjoy their rights across all sectors of development. The former free maternity services now the "Linda Mama Program" in Kenya, promotes reproductive health services to all women in Kenya. Operationalization of youth friendly clinics in nearly all public hospitals helps protect health of all youth through promoting their human rights, especially the SRHR as provided in the Youth Friendly Service Guidelines.

Despite these efforts YWD are neither knowledgeable nor aware about their rights which they are denied in their day to day lives. It's been noted that sexual relationship have become hard to handle and having a disability complicates the situation. As per The Convention on the Rights of the Child on expression from a historical, social policy and educational perspective society believes that YWD are asexual and cannot be abused (Verhellen, 2015). Some YWD lack information or means to make choices. Others face challenges including but not limited to coercion, discrimination or violence when exercising their rights. Some go through uncertain relationships, their marriages are disapproved and in some cases legally banned (Groce *et al,* 2013). Specific forum to channel YWD problems legally or at community level are not well spelled out.

The proportion of people with various disabilities in Kenya is 3.5% of the total Kenyan population (approximately 1.3 million people) (KNBS, 2013). This population cannot be ignored especially in national planning and development. When an offspring develops an impairment, it is generally seen as a curse by the household and society. These YWD are hidden in homes away from the public or from communal activity for fear of what the community will say. They have not been regarded as other 'normal' humans and their rights have greatly been denied especially their SRHR. People with disability has been seen by society as incapacitated and hence society has embarked to take them to the streets so that they may be a sight of pity for donations.

In a study on the challenges facing individuals with impairment in getting reproductive health services in government amenities in Nairobi showed the proportion of youth with disability accessing reproductive health services as at 21% (ICF, 2016). Since youth form 21% of the Kenyan population (KNSPWD, 2008), violating their rights is denying Kenya its tomorrow's generation. This research therefore is aimed at assessing the level of

knowledge on SRHR among YWD in selected disability centres in Kisii County in order to put forward the finest strategies to ensure their rights are protected.

1.3 Justification

There are a few international studies dealing with the sexuality of physically handicapped adolescents (Seidel *et al*, 2013). YWD are among the underprivileged and demeaned of the world youth (Groce *et al,* 2013). Disability studies has been governed by the need of impaired themselves, service providers and policymakers in the west. Little has been done in the exploration of the dissimilar ways in which impairment might be constructed cross-culturally (Ginsburg and R app 2013). Former Nyanza province according to the national census, has been ranked with the highest proportion of persons with disabilities, (5.6%) (KNBS, 2013), also justifies doing the study in Kisii county.

1.4 Research Questions

i. What are socio-demographic factors associated with level of knowledge on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County?
ii. What is the level of knowledge on sexual and reproductive health rights among youth with disability in selected disability centres in Kisii County?
iii. What is the level of awareness on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County?
iv. What are the health system factors associated with level of knowledge on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County?

1.5 Null Hypothesis

There is no association between socio-demographic factors, level of awareness, health system factors and level of knowledge on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County, Kenya.

1.6 Study Objectives

1.6.1 Broad objective

To assess the level of knowledge on sexual and reproductive health among youth with disability in selected disability centres in Kisii County, Kenya.

1.6.2. Specific Objectives

i. To determine socio-demographic factors associated with level of knowledge on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County.

ii. To determine the level of knowledge on sexual and reproductive health rights among youth with disability in selected disability centres in Kisii County.

iii. To determine the level of awareness on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County.

iv. To identify the health system factors associated with level of knowledge on sexual and reproductive health rights among youths with disability in selected disability centres in Kisii County.

1.7 Significance and Anticipated Output

The research intended to promote SRHR among YWD thus ensure that they are protected and provided thus benefiting. The findings of the study promotes acceptance of YWD in the various spheres of life and incorporate them with their counterparts without disability in the family, community and in all other activities involving the youth. The study also

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creates awareness and promotes knowledge on SRHR among the disabled population, their families and the whole community. The study also provides a new body of knowledge to the existing literature.

1.8 Limitations and Delimitation

Anticipated limitations included negative religious views on sexual education and other reproductive health (RH) services to the youth. Assumptions by other health care providers that all youth should not readily access RH. Bias answers owing to the sensitivity of the topic on SRH and the inability to understand the language of some YWD.

The above limitations were defeating by confirmation that the examination was only for insightful purposes. They were guaranteed that the discoveries were private and just utilized for the expected capacity. Moreover, the study's intent was to help overcome the various SRHR violation situations that YWD find themselves in. The inability to understand the sign language was overcoming by use of an assistant researcher sign interpreter.

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1.9 Theoretical framework

This study was steered by the Social Model of Disability (SMD). It was formed in the 1970s in the Union of the Physically Impaired against Segregation (UPIAS) by persons of influence. Intellectual credibility was given to the SMD by the works of Vic Finkelstein (1980, 1981), Colin Barnes (1991) and especially Mike Oliver (1990, 1996). SMD touches on learning difficulties, emotional, mental health or behavioural problems. Oliver describes disability as an individual pathology focusing on the body (Oliver, 1990).

It focuses on disability as a complex interaction of social, cultural, political, economic, and biological elements. The model visualizes impairment as a communal rather than a personal problem. The principle precept of theory is on disability because of common systems and not shortages in the body or cerebrum of an individual. It sees incapacity as a

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repercussions of natural, social and attitudinal check that upset individuals with impedances from full cultural investment. It focuses on the elimination of communal and ecosystem barriers to maximum social, physical, occupation, and religious involvement.

1.10 Conceptual Framework

SRHR among YWD were assessed using various variables. The schematic conceptual framework shows that SRHR among YWD is dependent on knowledge on the SRHR. Socio-demographic and structural factors may impact on it. The individual and societal barriers faced by YWD while accessing reproductive health services were explored. Existing national and international laid down policies, laws and treaties are likely to alter the perception in regards to the SRH rights among YWD when implemented within various sectors and programs.

The study centres on the alteration required in society, in terms of opinion, social support, and physical structures for the disabled with the influence of the laid down policies both international and those within the local government in Kenya. This framework detects the capacity of environmental factors in the inception creation of impairment. This mainly concerns equality and this battle for fairness is compared to the battles of the socially demeaned YWD. Equal rights facilitate empowerment, ability to make determination and a chance for the YWD to live life to the fullest.

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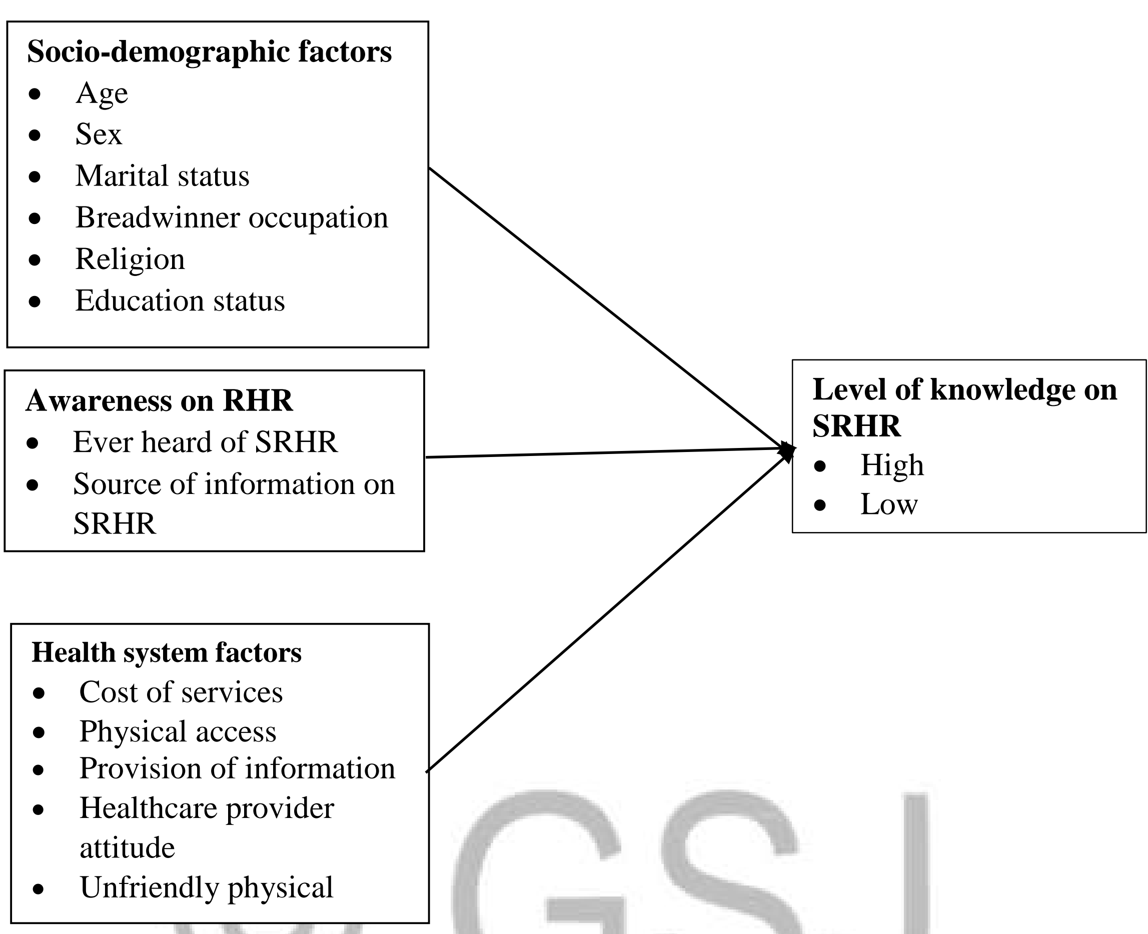

Fig: 1.1: The conceptual framework

Source Author: Adopted and modified from Finkelstein (1980).

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CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The literature review focused on the health system factors, socio-demographic factors, awareness on SRHR and knowledge on reproductive health rights.

2.2 Socio-demographic factors

Diverse social and social settings have shifting perspectives on people with disabilities with some giving PWDs status of "lesser individuals". UNAID News Letter (ICF, 2016), argues that communities, cultures and beliefs are so strong that when a disabled child is born or a person becomes disabled, the individual and family interprets this experience following the stereotyped notion their culture offers. These has led to isolation and neglect of people with disability. Young women with impairments are unlikely to be united in marriage as the first spouse in the existing polygamous communities. The right to bear children by the people with disabilities has been downsized and banned in many societies. This is contrary to the CRPD which seeks to advocate for the right to form marital affairs, marry, start a family and/or adopt children (CRPD, 2014).

Women with impairment have a probability of using long-lasting methods of contraception or none unlike their non-impaired counterparts. Women with more major impairment are more likely to have undergone hysterectomies or tubal ligations this is as per the Centre for Research on Females with Disabilities. A study in Nepal reveals unequal position in society of women with impairment than among other women in the entire populace. Hence they are not able to recognize their rights to a brutality free life, (Puri *et al,* 2015).

According to a study in Ethiopia on SRH, it is seen that YWD are sexually active unlike what society believes. The study findings included prevalence of unintended child-bearing being more than half of the participants among young impaired females. Half of them had

history of abortion and more than half of these abortions were induced. In the study, half of the sexually active participants had numerous life time sexual associates, some had occasional sex associate and few had a commercial coital associate in the former year preceding the study (Renzaho *et al.,* 2017).

In a study on socio-economic threats affecting parents with neurologic derangement whereby the major threats were the impoverished social life and thwarted economic condition which equally affected their siblings. The organization which support parents and the afflicted children should be supported socially to uphold society relationships, while enhancing health insurance coverage for the children in order to reduce the economic strains of their parents (Lawal *et al*, 2014). In the 2008-2009 KDHS revealed that 80% of women do not see any benefits of circumcision and these included women who had been circumcised while 59 percent said it didn't have any benefits but this is being practised in secrecy and especially on youth with disability (KDHS, 2014).

Persons with impairments bear SRH demands, and these demands transform over a lifespan. Diverse age groups mask diverse needs. Adolescents with impairment demand to be given information regarding their sexuality and may also demand exceptional arrangement regarding sexual offence and brutality, and the right to be safeguarded from it. It is paramount that services of SRH be amiable to impaired youth. In a study done in Ethiopia on SRH of impaired youth, it was reported that numerous participants were aged 20 years (Kassa *et al.,* 2014). In a report on youth and sexuality age was associated with the level of knowledge on reproductive health (Groce & Kett, 2014). In another study done in a slum area in Kampala, Uganda on SRH needs and rights among individuals with disability, age and level of knowledge did not have any statistical relationship (Renzaho *et al.,* 2017).

Marital status has been associated with influencing the level of knowledge as well as awareness on reproductive health rights. A study done in Awabel District in North-West Ethiopia, majority of the respondents were single (Ayehu *et al.,* 2016). In another survey on SRH and disability in humanitarian situations in Kenya, Nepal and Uganda established that marital status positively affect the knowledge level on reproductive health rights (Tanabe *et al.,* 2015). This is due to the fact that when people are in a relationship or active sexually, they tend to seek more information just as utilize reproductive health services in this manner getting more learned on their regenerative wellbeing rights. In Senegal, an investigation was done on difficulties and empowering influences to getting to sexual and regenerative wellbeing administrations among youngsters, it was noticed that conjugal status and information on sexual and reproductive health rights did not have any connection (Burke *et al.,* 2017).

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According to study done in Ethiopia on KAP on SRHR among young people with disability, it was disclosed that more than half of the respondents had impaired mobility (Kassa *et al.,* 2016). In another study done in Senegal, majority of the respondents were visually impaired. However, in most studies done, the degree of disability has never had an influence on level of knowledge (Burke *et al.,* 2017). This may be because individuals who are disabled are seen as outcasts and face almost similar challenges when dealing with accessibility of reproductive health services thus limiting their level of knowledge.

According to a study done by Burke et al (2017) in Senegal, most of the youths with disability interviewed were female. In another study done in India on adolescent health, most of the respondents interviewed were male (Sivagurunathan *et al.,* 2015). A research done in United States of America on sexuality of youth with mental and developmental impairment, it was reported that women were disproportionately affected and neglected in terms of their reproductive health rights (Ballan & Freyer, 2017).

Religion has been noted to take an important role in relaying information with regarding reproductive health rights. In a research done on availability to SRHRs schooling among minimized adolescents in chose regions of Tanzania, most of the respondents were Christians (Ngilangwa *et al.,* 2016). Religious leaders assume a crucial part in the scattering of sexual and reproductive health data during church sessions. A study done in Ethiopia, religion was significantly influenced the level of knowledge on SRHR among respondents (Aderemi *et al.,* 2014). This may be as an outcome of devout and cultural barriers, especially in the Muslim denomination where use of contraceptives is highly prohibited thus affecting their knowledge.

Having children is being a key issue especially among the disabled. Youth living with disability have been always been exposed to violations especially regarding practising their RH rights. This is because they are seen as outcasts and hence they are not supposed to enjoy their reproductive health rights. A research conducted in South Africa on SRHRs information, majority of the respondents interviewed had children (Waldman & Stevens, 2015). In other studies, done on accessibility of SRH services among people with physical handicaps, it was noted that there was no connection between the number of children and knowledge on SRHRs (Dossa *et al.,* 2014).

In low revenue countries, people with impairment do not go for normal education programs due to structural incapability which hinders them from accessing basic education (Schalet *et al.,* 2014). This therefore gives room for enrolment in vocational training as revealed by the results of this study. A study done by Pan *et al* (2015), it was accounted for that instruction was altogether connected with the degree of information on conceptive wellbeing rights.

People living with disability have been under the care of their parents, relatives or siblings to assist them in day to day activities as their breadwinners. Their parents have been of great help and a sole source of support in cases where they are discriminated. According to a study done in Senegal where, it was revealed that parents were the sole breadwinners of youths with disability (Kasser *et al.,* 2016). A research carried out by Seng *et al* (2019), it was shown that partners to people living with disability were their breadwinners. In a study done in Addis Ababa in Ethiopia, among visual and mobility impaired youths where it was revealed that the same individuals were their own breadwinners (Nigusie, 2016).

2.3 Knowledge on Sexual and Reproductive Health Rights

For the rights to SRH autonomy to be achieved comprehensive sexuality education is a crucial part. The Convention on the Rights of Persons with Disability (CRPD) in article 23 recognises the value of sexuality education in fulfilling SRHR, it notes that YWDs should have access to age suited information, procreative and birth control, to be acknowledged and the methods required to enhance them apply these rights once they have been granted (Atuymabe *et al.,* 2015).

SRH education for children and YWDs has not been given at home and they have often been denied formal education. These has led to most YWDs who cannot study, and even those who are knowledgeable through rehabilitation may not have adequate education to be health literate (UNFPA, 2016). Every type of disability is perceived differently by the Public. Most of YWD will confront discrimination and stigma in their everyday lives. This discrimination comes full circle the fending off of a wide scope of common liberties and opportunities particularly opportunity of development and relationship to wellbeing instruction and a mission for a work (Clement, 2013). Different examinations have noticed that the arrangement of data to teenagers expands their use rates on conceptive wellbeing administrations in this way getting more mindful of their privileges in youth friendly

centres (Mosavi *et al.,* 2014 and Temmerman *et al.,* 2014). Shortage or inaccessibility of realities is an obstruction to looking for conceptive wellbeing administrations among individuals living with incapacities according to an investigation on sexual and regenerative wellbeing privileges of women and girls with disability (Frohmader and Ortoleva, 2014).

Some caregivers and instructors fear that inculcating lessons on sex to individuals with mental disability would make them immoral, and/or more likely to commit sexual offenses (Atuymabe *et al.,* 2015). For children to realise their potential education is a critical and crucial component. United Nations Sustainable Development Goals (SDG) calls for positive transnational governmental support of inclusive education. YWD are seen as incapable of learning hence should not receive any form of education (ICF, 2016), these has contributed to high risk of illiteracy. It has been estimated that almost all (98%) of the children with impairment in emerging countries do not go to school (Sharma, 2015).

In Bangladesh a small proportion of YWD had completed primary school in contrast to those with no disabilities (GMR, 2013). A study in Indonesia on sex education among the disabled, from the teachers' gender perspective revealed lots of significance in sex education, nonetheless, the researcher expressed fears of limited content. The study showed female instructors are more positive about instructing on sex information than male teachers (Tsuda *et al*, 2017). India's 2002 National Sample Survey analysis by World Bank shows approximately 75% of children in India with severe impairments are not in school, unlike those children with mild or moderate impairments (Sharma, 2015).

On sexuality issues among the youth with disability it is indicated that most disabled youth have earned some kind of reformation for their bodily impairment but sexuality, HIV and AIDS issues are not part of the reformation course of action (Rohleder, 2018). A study on

knowledge, practice and attitude in Ethiopia revealed that nearly half of YPWD are familiar with SRH services, whereby Radio and TV were found to be the main origin of information to the participants. More than half of those involved in the study had never had a conversation on SRH topics. Almost all of the respondents had heard about HIV, but more than half had meagre knowledge about ways of its prevention (Kassa *et al,* 2016). A commission of inquiry in education in 1999 in Kenya on people with impairment, 25% were children of school going age, 12% of whom had been identified and assessed. While 2% had been enrolled in academic programs that gratified to their needs, 98% remained excluded from the education system (Chomba *et al*, 2014).

2.4 Awareness on sexual and reproductive health rights

Studies done on awareness on SRHR have shown that due to neglect, youths with disability have not enjoyed the same privilege with their normal counterparts. This may be because, sexual and reproductive health is a sensitive issue and they are seen as not entitled to their sexual desire. A study done in Ethiopia on sexuality and RH of impaired youth, it was reported that 64.6% of the participants were aware of their SRHR (Kassa *et al.,* 2016).

In another survey in Tanzania, the awareness level on SRHRs was 55.1% meaning the respondents were aware of their SRHR (Ngilangwa *et al.,* 2016). A survey done on trials faced by women with impairment in obtaining SRH in Zimbabwe, majority of respondents were not aware on their SRHRs (Rugoho *et al.,* 2017). In another survey done on SRHRs in India, low awareness levels were reported among people with disability facing numerous challenges in access to sexual and reproductive health services (Dean *et al.,* 2017).

According to Kasser *et al* (2016), major sources of information on SRH information was from radios and televisions. A study done on awareness of sexuality awareness and health

reproductive of people with physical disability in Vietnam, people revealed that most of the sexual education activities were taught in schools (Nguyen *et al.,* 2018). Peer education has also been noted as one of the platforms where information on sexual and reproductive health has been shared (Ngilangwa *et al.,* 2016).

2.5 Health system factors and Knowledge level on SRHR

PWDs sexuality have been neglected and their reproductive rights, refused. Current policies and programmes target on the prevention of childbearing but overlook the fact that PWD will in the end bear children. At worst, forced abortion and forced sterilization have often been enforced on PWD. Moreover, for many reasons, SRH services have been unattainable to individuals with disabilities, including the absence of disability-akin clinical services, physical threats, stigma and favouritism (Atuymabe *et al.,* 2015).

A study done in the highland Ecuador investigating the perceptions of individuals with physical and visual impairments, it was realised that they encounter inaccessible urban spaces due to their body physique, it should be pointed out that beyond impairment-specific mechanisms, the basic human rights conference also pursues to talk about the rights of PWDs (Rohleder, 2018). For example, the Convention on the Elimination of all Discrimination forms against Women (CEDAW), explore on the needs of all women with or without an impairment. In a study on the impaired within Zimbabwe, it was acknowledged that PWDs encounter threats in accessing services with the main impediment being limited disability information, accessibility, and outrageous user costs among service providers (Chomba *et al*, 2014).

A study in Uganda on challenges on accessibility of sexual and reproductive health services, societal demeaning of PWPDs was evidenced by the manner in which they were handled as they travelled to seek care, inclined to their low economic status. Most PWPDs

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in this research utilized public transport whereas only quarter of the respondents utilised private means to travel in search for healthcare. The encounter with public transport was illustrated as an ordeal for PWPDs symbolised by demeaning by both the taxi drivers and fellow commuters (Ahumuza *et al*, 2014). High dropout rate from schools among young girls with disability was due to inaccessible toilets. This was due to a project on school pit latrines that did not take into detail the distinct demands of girls with impairments, thereby undermining both their right to learning and SRH (Frohmader and Ortoleva, 2014).

A study in Ghana on threats women with impairment encounter in utilizing and accessing maternal healthcare services suggest that, their impairment usually make it challenging to access skilled care. They encounter unfriendly physical health infrastructure, healthcare workers' negligence and inadequate expertise about the maternity care demands. The study also showed that they also face biasness of service providers. The existing image that women with impairment should be asexual, and also acquire health advice that is non-specific, (Ganle *et al*, 2016). Study on the threats faced by PWPDs in approaching SRH services in Kampala, Uganda showed that PWPDs bumped into health facility-akin economic, and societal threats including physical inaccessibility, unfavourable attitude of health care providers, lengthy queues, services fees and demeaning in the society, (Dew, 2013; Ahumuza *et al*, 2014).

A research in Masvingo, Zimbabwe on the notion of deaf youth about their susceptibility to SRH problems pointed out that the sexuality of people living with impairments was not well known and overlooked thereby placing them at risk of SRH problems as well as exposing them to sexual violence. These therefore requires proper provision of SRH services and inclusivity (Atuymabe *et al.,* 2015). A research on sexual susceptibility and HIV Sero-prevalence amid the deaf in Cameroon acknowledged that the deaf people were deeply involved in unsafe sexual practices, (De Beaudrap, 2016).

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There have been low rates of reproductive health services utilization among youths with disability (Nguyen *et al.,* 2016). A study done on claiming SRHRs, reproductive health rights utilisation was linked with knowledge on SRHRs (Addlatha *et al.,* 2027). In fact, thorough utilization of such services, individuals stand at a better chance to know that the services they get are truly what they required. A research conducted in the Philippines on sexual and reproductive health services for ladies with impairment, people recognized their rights but had lower utilization of RH services (Lee *et al.,* 2015).

A study done on adolescents with specific demands have clinical problems in RH care, it was noted that lack of knowledge on availability of RH services affected the level of awareness and knowledge thus consequently affecting their utilization rates (Quint, 2016). In another study done in Ghana on difficulties women with handicaps experienced when accessing and using maternal healthcare services, availability of RH services affected the level of knowledge on reproductive health rights among those interviewed (Ganle *et al.,* 2016). Perceived obstacles for getting to wellbeing administrations among people with inability in four African nations showed that landscape and distance to wellbeing offices influenced the accessibility of conceptive wellbeing administrations (Eide *et al.,* 2016).

A research conducted in Durban South Africa on accessibility of sexual and reproductive health services, practises and outlooks of people with handicaps, reproductive health services were provided with high costs (Mavuso & Maharaj, 2015). In another study on efficient policies to give sexual and reproductive health services to adolescent, it was noted that reducing costs increases demand for RHs increased access to and awareness on RH (Denno *et al.,* 2015).

Poor attitude from healthcare providers means that patients may shy away from seeking such services due to unfriendly welcome. An examination was done on medical care

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suppliers' mentality towards incapacity and the experience of ladies with inabilities in the utilization of maternal medical services administrations in country Nepal, negative attitude discouraged use of sexual and reproductive health services (Devkota *et al*., 2017). A research carried out in Ghana, established that healthcare providers' insensitivity positively affects the utilization of RH services (Ganle *et al.,* 2016).

Access to reproductive health services has been affected by the nature of the physical infrastructure in the hospital settings. A study done in Nepal, Kenya and Uganda, wheelchair availability, sign language use significantly affected accessibility of reproductive health services among people with handicaps (Tanabe *et al.,* 2015). In South Africa, it was noted that medical infrastructure should be developed and provided to incorporate the unique needs of people living with disability (Gichane *et al.,* 2017).

Waiting time has influenced access to services as people may feel tired before receiving services and therefore shy off. A study done in Democratic Republic of Congo, where long waiting time in a violent set up influenced utilization of reproductive health services. This means that individuals were unable to enjoy reproductive health services as part of their rights (Ivanova *et al.,* 2018). In Ethiopia, long waiting time meant clients missed reproductive health services as they tired off in long queues before they were they received assistance (Ayehu *et al.,* 2016). In another research conducted in Ghana, Uganda and Zambia on accessibility to HIV services for persons with disability living with HIV, it was noted that women did not want to wait in queues because other responsibilities (Tun *et al.,* 2016). In another study done on factors influencing teenage antenatal care utilization in John Taolo Gaetsewe district in Northern Cape Province in South Africa, long waiting time led to women not going for all the required ANC and increased chances of home deliveries (Worku *et al.,* 2016).

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2.6 Policy Factors

Political factors is an entity for campaigning for and battling for rights and approach to services for the impaired population. It also includes them in National progress through subsequent laid down laws and policies. United Nations works to seek the objective of full participation of PWD in all attributes of companionship and advancement as entrenched in two main policy documents: 'World Programme of Action regarding Disabled Persons' and 'the Standard Rules on Equalization of Opportunities for PWD' which are both influential tools to endorse fairness and empowerment of PWD.

The legal and policy climate configures the opportunity of health services and schedules as well as the extent to which they are conscious to the defined wants and ambitions of positive individuals. Law and communal policy are also essential tools with which to impact the social and economic situation: building up positive communal enticement and the creation of the process of addressing those social norms that aggravate inequity of rights leading to violation, (Word Bank, 2006). A UK based survey done exploring on women with learning impairments opinion on family planning indicated that crucial verdicts over care on family planning are often formed by other people and not the individuals themselves (Ledger *et al*, 2016).

Human rights contribute a legal context within which national laws, policies and services can be developed and gauged, as well as a way to the layout of policies and schedules. The absence of clear international political engagement to the reproductive and sexual rights of disabled youths presents a frequent threat. On track with Article 4 (General Obligations) of the CRPD, UNFPA, WHO, and other agencies must perceive the ability of PWD and urge partnership in policy building with systems of PWD. PWD have often been refused the right to form marriage relationships and to determine whether, when, and with whom

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to have a family. Many have been exposed to violent sterilizations, violent abortions, or violent marriages (UNFPA, 2016).

Globally disabled women explicit worry concern about the rise in eugenics health laws that segregate against disabled persons by denying them to become a parent or to sire as per the Disability International. In china diverse rules have been passed to protect the principles and concerns of the adolescent, youth and the elderly with disabilities. These includes the law on the defence of the impaired people and the Ninth 5-Year blueprint gives the disabled the assurance of equal rights, (Lee *et al.,* 2015).

A study done on **SRHR rejection and exploitation of women with psychosocial impairment in Mexico** shows that the Mexican government had declined to implement policies that protect safe approach to SRH services, on an balanced basis with others. Almost half of the women consulted experienced exploitation while visiting a gynaecologist, including sexual exploitation, rape, and forcefully sterilized or had been intimidated by household members to go through the surgical operation. Also women and girls detained in institutions underwent pervasive abuses and violations of reproductive health rights (DRI, 2015).

In Uganda the policy emphasizes that an adolescents is entitled to go to any health centre that accommodates them. The facility must have specifically trained non-judgmental, positive attitude centred staff available and accessible at all times who regard their SRHR and they should have adequate time for provider interaction as well ensuring presence of peer counsellors. A research in Ghana on SRHR policies on disability revealed an unfavourable image about impairment and lack of societal perceptive of the interests of PWD, (Mprah *et al*, 2014).

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2.7 Gaps on reviewed literature

SRH and SRHR is a key facet of human development aimed at providing a healthier workforce. This literature review identified gaps on factors affecting exercise on SRHR among the disabled youth, cultural hindrances to obtaining knowledge on SRHR, lack of capitation of YWD needs and on actual statistics of YWD.

CHAPTER THREE: MATERIALS AND METHODS

3.1 Study Design

This was a descriptive study of a cross-sectional manner. It was naturalistic study that intended to define the population at the point in time to help characterize the status of SRHR on the study population.

3.2 Variables

3.2.1. Independent Variable

The predictor variables comprised of socio-demographic factors, awareness on SRHR and health system factors that may influence awareness on SRHR. Socio-demographic and health system factors were measured using checklist with options from which the study respondents picked the most appropriate answers. The awareness was measured by asking the respondents whether they ever heard of SRHR. The information sources from which the participants got the information were also considered.

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3.2.2 Dependent Variable

The dependent variable of this survey was knowledge on SRHR. With regards to this, the respondents were given five (5) questions on SRHR with options. Each right response was accorded a mark (1) while an improper response was accorded a zero (0). The scores ranged from 0-5 marks. The scores of knowledge were also dived into two groups; high knowledge level ranged from 3-5 scores while low knowledge level ranged from 0-2 scores.

3.3 Study Location

The survey was done in Nyaribari-Chache constituency. The constituency is situated in Kisii County, among the six counties in the former Nyanza province. Narok borders it to the South, Nyamira to the East, Bomet to the South East, Kisumu to the North, Homa Bay to the North West and Migori to the West. The study was conducted specifically in selected

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disability centres. This included Kisii Special School for the mentally impaired, Gianchere special school for the hearing impaired and the Association for the Physically Disabled of Kenya – Kisii Branch. Nyaribari Chache has many numbers of special schools situated in the constituency. The number of youths with disability enrolled in the study area are totalling to 2182 with 1568 in special need centres and 614 in the APDK (Field data, 2016).

3.4 Study Population

Youths with disability in disability centres were targeted. The study specifically focused on YWD enrolled in the selected disability centres in Kisii County, aged 15-24 years. The complementary target group (key informants) was the stakeholders from the selected disability centres. The population whom the results would be generalised was the youth with disability from the study area totalling to 2182. The total population of youths with disability enrolled in Kisii Special School, Gianchere Special School and APDK Kisii branch were 170 (Site register statistics, 2016).

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3.4.1 Inclusion Criteria

The study included youth with some form of disability, aged 15-24 years. The respondents must have been enrolled in a special need centres at the time of the study. Those who consented were enrolled for the survey.

3.4.2 Exclusion Criteria

Those who were seriously sick during the survey and not able to converse or reply were excluded.

3.5 Sampling Techniques

Kisii County was conveniently selected being one of the six counties in the former Nyanza province that was ranked with the highest proportion (5.6%) of PWD (KNBS, 2009) and with 21% of YWD aged 15-24 (KNSPWD, 2013). Nyaribari Chache constituency was

purposively selected due to the many numbers of special schools situated in the region. Three disability centres for the youths were purposively selected for the study. These included Kisii Special School for the mentally impaired, Gianchere special school for the hearing impaired and the APDK –Kisii Branch. These institutions have a large number of the disabled population and have served in the area (Kisii County) for more years than the rest of the other institutions. The respondents from each disability centre were selected through simple random sampling using computer generated numbers. The participants opted for from each disability centre were proportional to the number of youths with disability in the selected centres. A total of 130 respondents were recruited for quantitative study. For qualitative data, two stakeholders from each special school were selected for key informant (KI) interviews. A total of six (6) key informants were interviewed for additional information. The KIs were purposively selected with the help of the county Director of education in regards to them being well versed with knowledge in the disability sector of education in the county. One focused group discussion was held in each selected disability centre. Therefore a total of three FGDs were held. The FGDs comprised of eight participants selected purposively depending on their intention and need to participate in the study.

3.6 Sample Size Determination

Computation to determine the sample was by use of Fisher et al formulae (1998).

For populations more than 10,000;

$$\mathrm{n} = \frac{Z^2pq}{d^2}$$

$$\mathrm{n} = \frac{1.96^2 \times (0.5)(0.5)}{0.05^2} = 384$$

For populations less than 10, 000, a correction formula was used;

$$nf = \frac{\mathrm{n}}{1+\mathrm{n}/\mathrm{N}}$$

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$$nf = \frac{384}{1+\left(\frac{384}{170}\right)} = 118$$

Where;

n= the desired sample size (when target population is greater than 10,000.

N= approximate number of youths with disability in selected disability centres.

z= the standard normal deviation at 95 % confidence level.

p= assumed proportion of youths with disability aware of their SRHR (50%=0.5)

q=1-p=0.5

d= the level of statistical significance set at 5% =0.05

An addition 10% of respondents was done to cater for non-respondents making the total sample size to be 130 people. The table below shows the proportionate sampling from the selected three institutions.

Table 3.1: Sampling frame

Centre	Centre Population	No of YWD aged 15-24 years	Sample size
Gianchere special school	143	30	23
Kisii Special school	52	11	8
APDK Kisii branch	614	129	99
Totals	**809**	**170**	**130**

3.7 Construction and pre-testing of data instruments

The study employed three data collection instruments: Questionnaires, focused group discussion guide and key informant interview schedules. The research instruments covered all the research objectives. The key areas included socio-demographics, awareness, health system factors and knowledge on SRHR. The research tools were pretested with 10% of respondents (13) at Kerina Special School in Bonchari Constituency in Kisii County.

3.7.1 Validity

Validity alludes to how strong a tool measures what it is expected to measure. Validity was guaranteed through a specialist survey of the examination apparatuses with the bosses.

The investigation embraced examining strategies that brought about a randomized and delegate test. Random examining strategies and consistency of inspected populace guaranteed internal validity. For guarantee external validity, a large sample was selected randomly.

3.7.1 Reliability

Reliability is the magnitude to which a study tool gives reproducible results (Mugenda and Mugenda, 2003). Reliability of research tools was ensured by appropriate choosing of assistants. They were enough trained and acclimated with the investigation region and subject of study before collection of data. The study instruments were pre-tested in the field before the real study was done. This was to guarantee they were obviously perceived by the exploration respondents and essential redresses made (Sekaran, 2013).

3.8 Data Collection Techniques

Data was gathered by trained research assistants trained. Training was done a week prior to the study period. Data was collected for three months using the pretested tools. Quantitative data was collected using questionnaires administered to 130 selected participants to fill in their responses. They were guided by trained research assistants. Qualitative data was collected using FGD and KII guides. Three focused group discussions were held, with each selected centre having one FGD. The respondents were purposively selected with the aid of their teachers, the participants were those whom the teachers knew bore the information and they would easily give it. Each FGD consisted of eight participants. The sessions were moderated by the researcher in assistance with the research assistants with the help of the focussed group discussion guide. The respondents were probed to give more information on awareness on sexual and reproductive health rights. There inputs were recorded via tape recorder, and short notes taken by research assistants during FGD sessions. The sessions were held in private rooms within the disability centres.

Six (6) key informants were also interviewed. The key informants were selected after them being identified to be knowledgeable about the topic and they were those officers who worked closely the disabled population in Kisii Two directors from each centre were recruited for interviewing. The sessions were held in their offices on the appointment days they proposed. Their inputs were also recorded in form of notes and audio tapes.

3.9 Data Analysis and Presentation

After data collection, data were scrutinized for completeness and certainty and then safely kept. They were then entered in Microsoft excel before being imported to Statistical Package for Social Sciences version 22.0 for analysis. Descriptive statistics for quantitative data were calculated and later presented in frequency tables, pie charts and graphs. Inferential statistics were also calculated using Chi square test at 95% confidence interval with p-values less than 0.05 considered significant. This was employed to show the association between independent and dependent variables. Qualitative data was analysed in patterns and themes formed. They were triangulated with quantitative data and presented in narrative and verbatim forms.

3.10 Ethical Considerations

Authorization letter was given by Kenyatta University graduate school. Ethical consent was solicited from Kenyatta University Ethical and Review Committee. The study further sought authorization from the National Commission for Science, Technology and Innovation (NACOSTI) before collecting data. The researcher also got permission from Kisii County. Further permission was obtained from relevant authorities in the various disability centres where data was collected. The researcher obtained individual informed consent from the respondents before data collection while minors were only enrolled in the study after permission was granted from either one parent, legal guardian present or the school heads. Confidentiality was ensured as the information gotten was used for

educational purposes only. Respondents were allowed to participate voluntarily and anonymity was ensured as they were not to write their names on the instruments.

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CHAPTER FOUR: RESULTS

4.1 Introduction

The scholar gave 130 questionnaires to chosen youths with disability in selected disability centres in Kisii County. Consideration for the study was given to the appropriately filled and returned surveys. The information was checked and cleaned and 127 questionnaires were considered fit for research addressing a 97.69% response rate. This response rate outperformed the minimum sample focused for this research accordingly sufficient for analysis.

4.2 Socio-demographic characteristics of the respondents

The results indicated that the participants were at least 15 years of age. Slightly less than a third 40 (31.5%) of the participants were between 18-20 years of age, 36 (28.4%) were 21-23 years old. On marital status, majority 75 (59.1%) were single. Concerning the respondents' disability, slightly less than half 63 (49.6%) of them had physical impairment. More than half 72 (56.7%) of the respondents were male with the rest 55 (43.3%) being females. Regarding the respondents' religion results revealed that majority 116 (91.3%) of them were Christians whereas the others 11 (8.7%) were Muslims.

Majority 99 (78.0%) of the respondents did not have any children while the remaining 28 (22.0%) had children. Results further indicated that slightly less than half 60 (47.2%) of the participants were involved vocational trainings followed by 43 (33.9%) who were involved in the normal curriculum. Less than a third 39 (30.7%) of the respondents reported that the breadwinner was the father followed by 38 (29.9%) whose breadwinner was the mother. Regarding the respondents' breadwinners' occupation results revealed that less than half 53 (41.7%) were peasant farmers followed by 35 (27.6%) whose breadwinners were self-employed. The results were displayed in below:

Table 4.1: Socio-demographic characteristics distribution among participants (n=127)

Variable	Participant response	Frequency (N)	%
Age in years	15-17	31	24.4
	18-20	40	31.5
	21-23	36	28.4
	24	20	15.7
Marital status	Single	75	59.1
	Married	20	15.7
	Widowed	8	6.3
	Separated/divorced	8	6.3
	Engaged/in a relationship	16	12.6
Degree of disability	Deaf/impaired hearing	44	34.7
	Physical impairment	63	49.6
	Intellectual disability	20	15.7
Gender	Male	72	56.7
	Female	55	43.3
Religion	Christian	116	91.3
	Muslim	11	8.7
Have children	Yes	28	22.0
	No	99	78.0
Education involved	Vocational	60	47.2
	Normal curriculum	43	33.9
	Vocation & rehabilitative	24	18.9
Breadwinner	Father	39	30.7
	Mother	38	29.9
	Relatives	24	18.9
	Self	14	11.0
	Husband	12	9.5
Breadwinners occupation	Employed	28	22.0
	Self-employed	35	27.6
	Peasant/farmer	53	41.7
	Casual labourer	11	8.7

4.2.1 Socio-demographic characteristics' influence on level of knowledge on reproductive health rights

The research attempted to ascertain how socio-demographic characteristics influenced knowledge level on SRHRs among the respondents. The results showed 23 (41.1%) of the respondents who were 18-20 years of age had high knowledge level on their SRHRs. Age and level of knowledge on SRHR did not relate statistically (p=0.376). Majority 47 (66.2%) of the participants who were single possessed low knowledge level on SRHRs.

Marital status and level of knowledge on SRHRs related significantly (p*=0.001). Results from qualitative data revealed that those respondents who were married were interested to know about their rights especially when seeking for reproductive health services. One discussant during FGD sessions narrated:

"...it's good to have some basic knowledge on my rights so that they are not violated. Some of our rights are mainly violated because we don't know what our rights are with regards to reproductive health. I didn't know about my reproductive health rights until I had my first pregnancy, when we were educated on our sexual and reproductive health at the hospital. This is the time I realized that most of our rights were being violated because of ignorance ...."

Regarding the respondents' degree of disability, the findings indicated that majority 34 (60.7%) of the participants with physical impairment had high knowledge level on SRHRs. Degree of disability and knowledge level on SRHRs related statistically significant (p=0.001). The findings further disclosed that majority 39 (69.6%) of the male participants were highly knowledgeable on SRHRs. Gender and knowledge level on SRHRs had no statistically significant relationship (p=0.176).

The outcome revealed that majority 65 (91.5%) of the participants who were Christians had a low level or knowledge on SRHR. However, there did not exist any association between religion and knowledge level on SRHRs (p=1.000). On whether the respondents had children, results showed that most 63 (88.7%) of the respondents who had no children had low knowledge level on SRHRs. Having children and level of knowledge on SRHRs related statistically significant (p=0.001). This would be due to the fact that those respondents who had children may have attended ANC and benefited from health education thus improving their knowledge level.

Results further disclosed that majority 32 (57.2%) of the participants who were involved in vocational trainings had had high knowledge on SRHRs. Education involved in and level of knowledge on SRHRs associated significantly significant (p=0.030). Slightly less

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than half 25 (33.3%) of the respondents whose breadwinner was the mother had high knowledge level on SRHRs. There was a connection between breadwinner and knowledge level on SRHRs (p=0.001). Results from Key informant interviews revealed that youths with disability are taught and sensitized on SRHRs during trainings in training and vocational institutes as well as the normal health education sessions at the disability centres. Director of a Disability centre during KII session said:

"...we normally bring experts to teach and sensitize our youths on reproductive health issues. Information is power and when you provide essential information it increases their knowledge and thus, they become aware of their rights. Thus, it becomes hard to violate their rights since they are aware of them. Some of the breadwinners or relatives also try to educate these youths on their rights especially those who live with their parents. In future we plan to educate the guardians of the youths on the sexual and reproductive health rights so that they can continue to teach them at home as well as help in reducing cases of violations not only home but also other social places..."

Concerning the respondents' breadwinner's occupation, it was indicated that less than half 32 (45.1%) of those whose breadwinners were peasants/farmers and had low knowledge level on their SRHRs. Breadwinners' occupation and knowledge level on SRHRs related statistically significant (p=0.001). The results were as presented in the table 4.2 below:

Table 4.2: How Socio-demographic factors and level of knowledge on reproductive health rights relate (n=127)

Independent variable	Respondent response	Level of knowledge on SRHR		Statistical significance
		High (N=56)	Low (N=71)	
Age in years	15-17	13(23.2%)	18(25.4%)	χ^2=3.104 df=3 p=0.376
	18-20	23(41.1%)	17(23.9%)	
	21-23	12(21.4%)	24(33.8%)	
	24	8(14.3%)	12(16.9%)	
Marital status	Single	28(50.0%)	47(66.2%)	χ^2=21.853 df=4 p=0.001 p*=0.001
	Married	8(14.3%)	12(16.9%)	
	Widowed	5(8.9%)	3(4.2%)	
	Separated/divorced	6(10.7%)	2(2.8%)	
	Engaged/in a relationship	9(16.1%)	7(9.9%)	
Degree of disability	Deaf/impaired hearing	14(25.0%)	30(42.3%)	χ^2=17.803 df=2
	Physical impairment	34(60.7%)	29(40.8%)	

	Intellectual disability	8(14.3%)	12(16.9%)	p=0.001
Gender	Male	39(69.6%)	33(46.5%)	χ^2=1.828 df=1 p=0.176
	Female	17(30.4%)	38(53.5%)	
Religion	Christian	51(91.1%)	65(91.5%)	χ^2=0.121 df=1 p=0.728 p*=1.000
	Muslim	5(8.9%)	6(8.5%)	
Have children	Yes	20(35.7%)	8(11.3%)	χ^2=10.887 df=1 p=0.001
	No	36(64.3%)	63(88.7%)	
Education involved	Vocational	32(57.2%)	28(39.4%)	χ^2=6.988 df=2 p=0.030
	Normal curriculum	12(21.4%)	31(43.7%)	
	Vocation & rehabilitative	12(21.4%)	12(16.9%)	
Breadwinner	Father	11(19.6%)	28(39.4%)	χ^2=34.160 df=4 p=0.001
	Mother	25(44.7%)	13(18.3%)	
	Relatives	5(8.9%)	19(26.8%)	
	Self	8(14.3%)	6(8.5%)	
	Partner	7(12.5%)	5(7.0%)	
Breadwinners occupation	Employed	23(41.1%)	5(7.0%)	χ^2=35.140 df=3 p=0.001 p*=0.001
	Self-employed	8(14.3%)	27(38.0%)	
	Peasant/farmer	21(37.5%)	32(45.1%)	
	Casual labourer	4(7.1%)	7(9.9%)	

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4.3 Knowledge on reproductive health rights

4.3.1 Responses on knowledge on SRHRs

Regarding knowledge, the respondents were given five (5) statements on reproductive health rights to which they indicated whether the statements were true or false based on what they think. The responses were captured as either correct or wrong. Regarding whether the respondents were allowed to plan a family, the results showed that majority 88 (69.3%) had correct knowledge while the rest 39 (30.7%) had wrong knowledge.

On whether the respondents could decide on the fate of their pregnancy results revealed that majority 83 (65.4%) had wrong knowledge while the rest 44 (34.6%) had wrong knowledge. Concerning one deciding on when to use contraceptive, results showed that more than half 68 (53.5%) had wrong knowledge while the rest 59 (46.5%) had correct knowledge. More than half 75 (59.1%) of the respondents correct knowledge on getting taught about sex education in public schools with the rest 52 (40.9%) having wrong

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knowledge. Further results disclosed that half 64 (50.4%) of the participants had wrong knowledge on accessing any reproductive health services whenever they needed them while 63 (49.6%) had correct knowledge. The outcome was as presented in the table 4.3 below:

Table 4.3: Responses on knowledge of reproductive health rights (n=127)

Independent Variable	Participant response	Frequency (N)	Percentage (%)
I am allowed to plan a family	Correct	88	69.3
	Wrong	39	30.7
I can decide on the fate of my pregnancy	Correct	44	34.6
	Wrong	83	65.4
I can decide on when to use contraceptives for family planning	Correct	59	46.5
	Wrong	68	53.5
I belief getting taught about sex education in public schools	Correct	52	40.9
	Wrong	75	59.1
I can access any reproductive health services whenever I need them	Correct	63	49.6
	Wrong	64	50.4

4.3.2 Level of knowledge on reproductive health rights

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Results regrading knowledge on reproductive health rights among participants are covered here. The five (5) questions on knowledge scored 0-5 marks. Every right response was assigned a1 mark score whereas a zero mark (0) was given to an unsuitable response. The scores of knowledge were further dived into two categories; high knowledge level ranging from 3-5 scores and low knowledge level ranged from 0-2 scores. It was indicated that more than a half 77 (55.9%) had low knowledge on reproductive health rights while the rest 56 (44.1%) had high knowledge. Figure 4.1 below displays the findngs:

Results from qualitative data revealed that the low knowledge level would be attributed to lack of interest and low levels of educational status among the respondents. During FGD session on respondent reported:

"…To be honest I have heard about that topic today. I have never had interest on the same…this because I do not have time to go for sensitization meetings because I have to make ends meet. I have two young children who depends on me. Maybe now that I have heard about its importance, I will try to seek the information and learn more...."

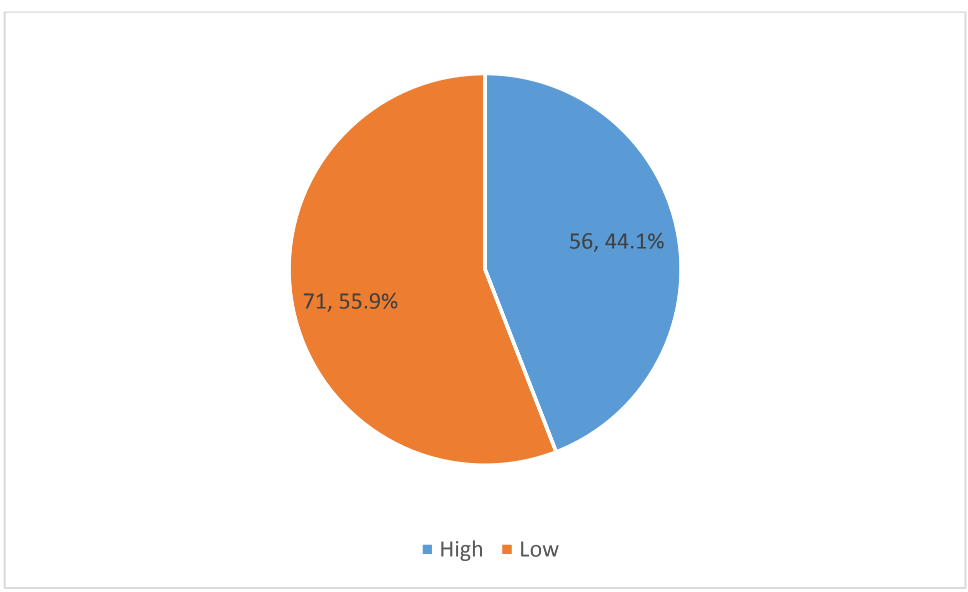

Fig 4.1: Level of knowledge among respondents

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4.4 Awareness on reproductive health rights

4.4.1 Ever heard of reproductive health rights

The study attempted to ascertain if participants were cognisant of their reproductive health rights. Findings disclosed that majority 75 (59.1%) were aware of their reproductive health rights while the rest 52 (40.9%) did not have any awareness. Figure 4.2 displays the results

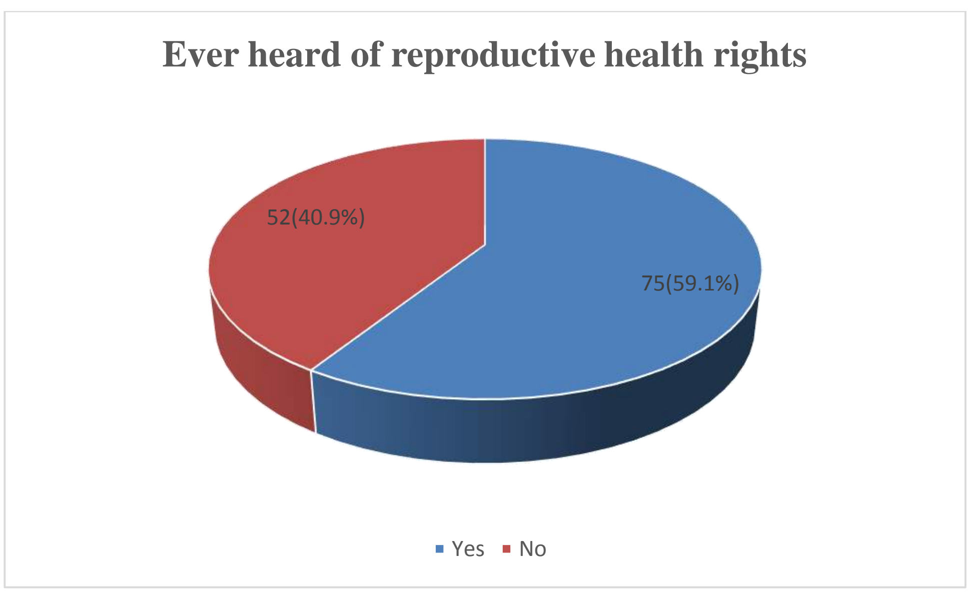

Fig 4.2: Ever heard of RHR among participants

4.4.2 Information sources on RHR

The research attempted to ascertain the information source on RHR among those participants who were aware of such rights. The results revealed that more than a third 28 (37.3%) heard about reproductive health rights from the media followed by 15 (20.0%) who learned about reproductive health rights from the health talks. The results were as shown in the figure 4.3 below:

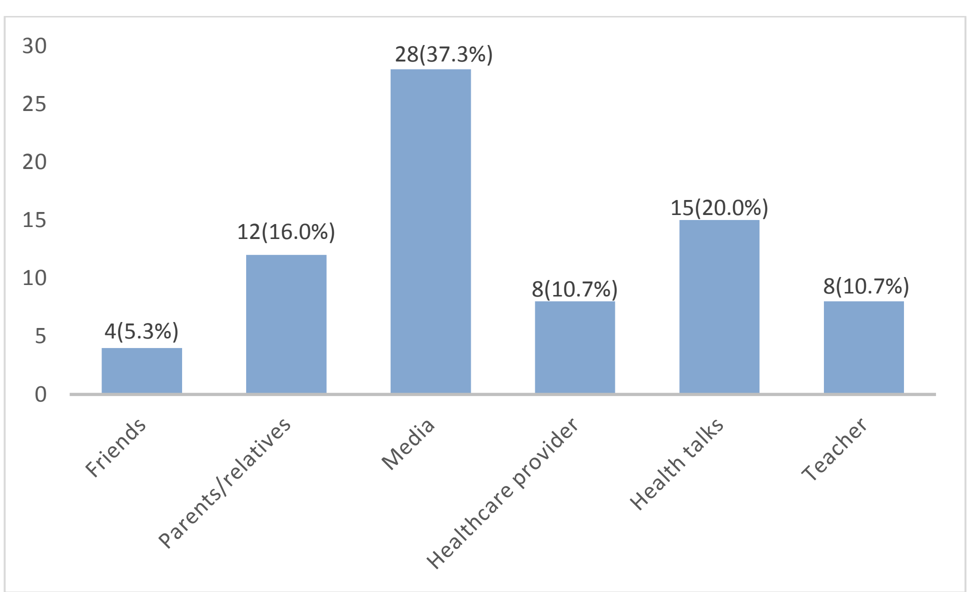

Fig 4.3: Information sources on RHR among participants

4.4.3 Number of reproductive health rights mentioned

The results revealed that less than 31 (41.3%) of the respondents were able to mentioned only one reproductive health rights followed by 20 (26.7%) who were able to name two reproductive health right. However, 16 (21.3%) were unable to name any reproductive health right and 8 (10.7%) were able to name three and more rights. Table 4.4 has the results

Table 4.4: Number of rights mentioned among participants (N=75)

Number of rights mentioned	Frequency (N)	%
0	16	21.3
1	31	41.3
2	20	26.7
≥ 3	8	10.7

4.4.4 Influence of awareness on level of knowledge on SRHR

The thesis aspired to find out how awareness influenced level of knowledge on SRHRs amidst the respondents. It was clear that majority 40 (71.4%) of the participants who had ever heard of SRHR had high knowledge level on SRHR. Awareness on SRHR and level of knowledge on SRHRs related significantly (p=0.012). Regarding the source of information on SRHRs, it was indicated that less than half 15 (42.9%) of the participants with low knowledge level on SRHRs picked media as the source. source of information on SRHR and level of knowledge on SRHR did not have any significant connection (p=0.071).

Concerning the number of RHR mentioned by the participants, results indicate that slightly less than half 17 (48.5%) of those who named 1 right had low level of knowledge on SRHRs. Further results disclosed that the number of SHRH mentioned and level of knowledge on SRHRs had a statistically significant connection (p=0.018). Table 4.5 summarizes the findings:

Table 4.5: Association between awareness and level of knowledge on RHR among participants

Independent variable	Participant response	Level of knowledge on SRHR		Statistical significance
		High	Low	
Ever heard of SRHR	Yes	40(71.4%)	35(49.3%)	χ^2=6.342
	No	16(28.6%)	36(50.7%)	df=1
	Total (N)	56(100.0%)	71(100.0%)	p=0.012
Source of information on SRHR	Friends	3(7.5%)	1(2.9%)	χ^2=23.648
	Parents/Relatives	5(12.5%)	7(20.0%)	df=5
	Media	13(32.5%)	15(42.9%)	p=0.079
	Healthcare provider	5(12.5%)	3(8.6%)	p*=0.071

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	Health talks	10(25.0%)	5(14.3%)	
	Teacher	4(10.0%)	4(11.4%)	
	Total (N)	40(100.0%)	35(100.0%)	
Number of reproductive health rights mentioned	0	5(12.5%)	11(31.4%)	χ^2=10.092 df=3 p=0.018
	1	14(35.0%)	17(48.5%)	
	2	15(37.5%)	5(14.3%)	
	≥ 3	6(15.0%)	2(5.7%)	
	Total (N)	40(100.0%)	35(100.0%)	

4.5 Health system factors

4.5.1 Ever utilized reproductive health services

The sought to determine whether the respondents had ever utilized reproductive health services, results revealed that most 95 (74.4%) had not utilized reproductive health service while the rest 32 (25.6 %) had utilized. The results were as shown in the figure 4.4 below:

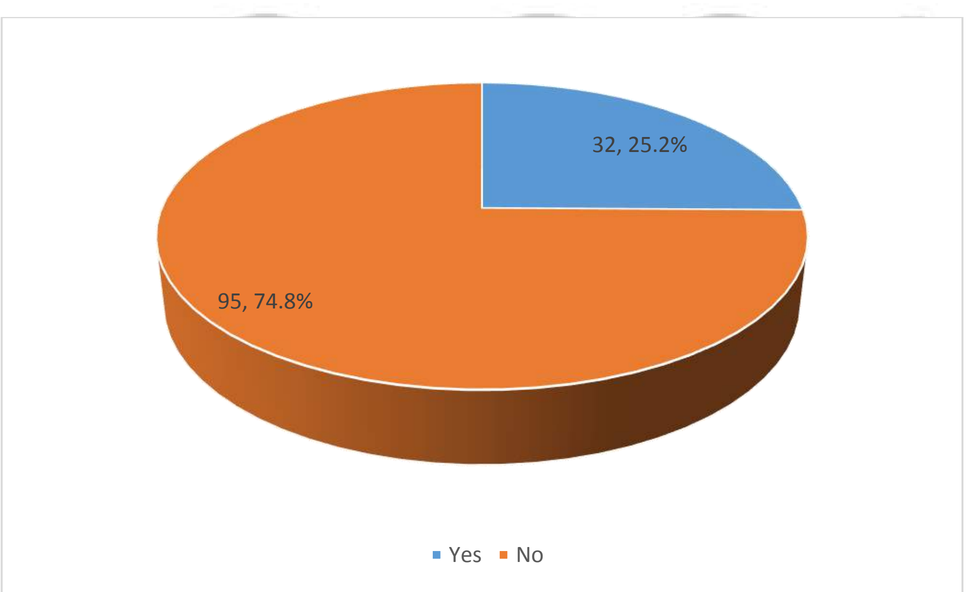

Fig 4.4: Reproductive health services utilization among participants

4.5.2 Facilities where services were sought

Regarding the facilities where services were sought, results showed that half 16 (50.0%) of the respondents sought the services at the public hospitals followed by 12 (37.5%) who sought the services from the youth friendly centers. The results were as shown in the figure 4.5 below:

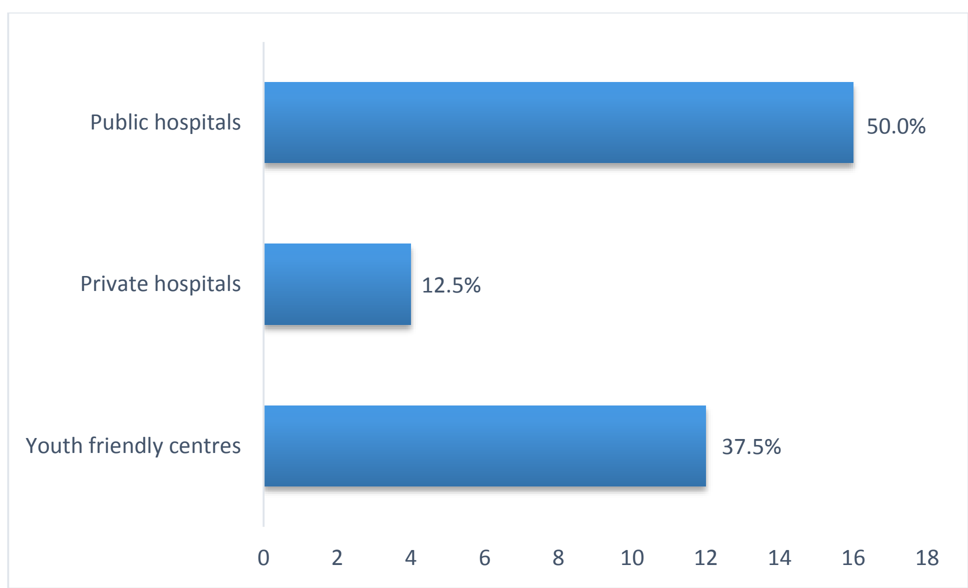

Fig 4.5: Place where reproductive health services were sought among respondents

4.5.3 Hindrance of disability on accessing reproductive health services

More than half 96 (75.6%) of the respondents accounted that disability was not a hindrance in accessing reproductive health services while the rest 31 (24.4%) revealed that disability was indeed an hindrance. The results were as shown in the figure 4.6 below:

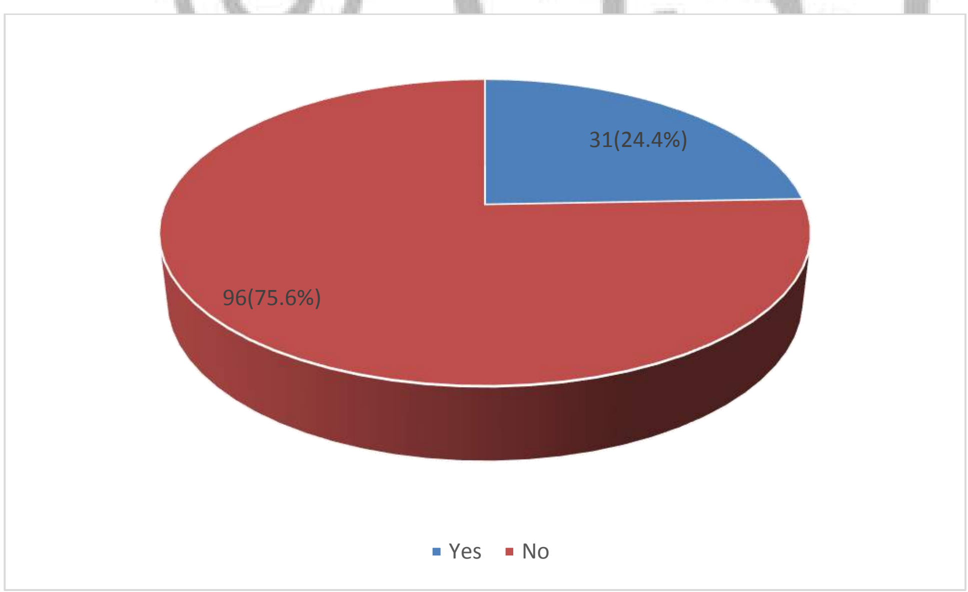

Fig 4.6: Hindrance of disability in accessing reproductive health services

4.5.4 Forms of hindrances to seeking reproductive health services

Among those who respondents who revealed that disability was a hindrance in accessing reproductive health services, results showed that 8 (25.8%) of the respondents reported that they needed protection from harsh health providers and 8 (25.8%) of the respondents whose parents insisted on escorting them. The results were as shown in the figure 4.7 below:

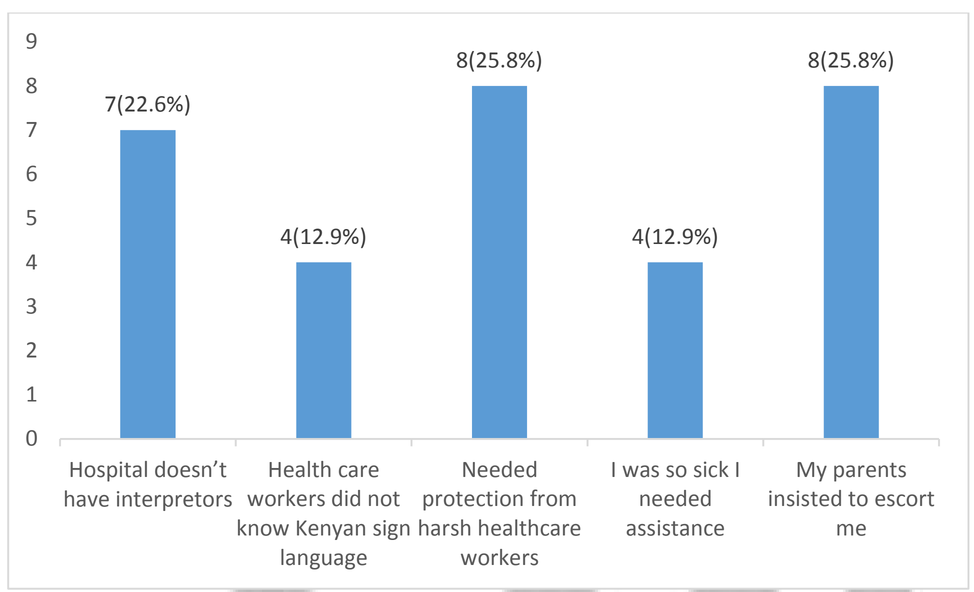

Fig 4.7: Forms of hindrances reported among respondents

4.5.5 Features of health facilities influencing service utilization

Concerning the features of health facilities could influence service utilization, findings pointed out that majority 68 (53.5%) of the respondents accounted that the RHS were not available to them followed by 47 (37.0%) who reported that they were available. Majority 72 (56.7%) of the respondents reported that reproductive health services were not affordable to them followed by 44 (34.6%) who felt that the services were affordable. Regarding the attitude of health care providers, less than half 59 (46.4%) of the participants cited that the healthcare provider's attitude influenced access to services followed by 51 (40.2%) who felt that attitude would not influence access to services.

Half 64 (50.4%) of the respondents disclosed that they were given information before provision of health care services followed by 43 (33.9%) reporting that they were not given any health information. Of the participants, slightly less than half 60 (47.2%) reported that unfriendly physical infrastructure affected their access to reproductive health services followed by 51 (40.2%) who reported that the infrastructures did hinder their access to services.

On whether the respondents experienced long waiting time while accessing health services, results discovered that majority 68 (53.5%) of them experienced the long waiting time while 36 (28.3%) did not experience. The findings were displayed on the table 4.6 below:

Table 4.6: Health system factors influencing SRHR service utilization (n=127)

Independent Variable	Participant response	Frequency (N)	Per cent (%)
RHS availability	Yes	47	37.0
	No	68	53.5
	I cannot tell	12	9.4
Affordability of reproductive health services	Yes	44	34.6
	No	72	56.7
	I cannot tell	11	8.7
Attitude of healthcare providers influences access to health services	Yes	59	46.4
	No	51	40.2
	I cannot tell	17	13.4
Given information before provision of services	Yes	64	50.4
	No	43	33.9
	I cannot tell	20	15.7
Unfriendly physical infrastructure	Yes	60	47.2
	No	51	40.2
	I cannot tell	16	12.6
Experienced long waiting time while accessing health services	Yes	68	53.5
	No	36	28.3
	I cannot tell	23	18.1

4.5.6 Health system factors' influence on knowledge on RHR

The study attempted to ascertain how health system factor influence on level of knowledge on SRHRs. It was revealed that majority 66 (93.0%) of the participants who had never

used RHS had low level of knowledge on SRHRs. Ever used reproductive health services and level of knowledge on SRHRs had a statistical association (p=0.019). Majority 46 (88.5%) of the respondents who reported that disability was not a hindrance to accessing reproductive health services had low level of knowledge on SRHRs. Disability being a hindrance to accessing reproductive health services and level of knowledge on SRHRs related statistically (p=0.001). Qualitative results established that disability indeed hindered access to information to SRH thus influencing their level of knowledge on SRHRs among the respondents. One of the Focused Group Discussants explained:

"…with my disability status I cannot be able to attend health talks I hear being offered at the health facilities. Sometimes I miss a lot of information on sexual and reproductive health because I cannot afford to buy a television or radio. I would like to know more about my rights so that I can tell when they are violated. Unfortunately, my present financial and disability status cannot allow me …."

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Concerning the reproductive health services availability, findings indicated that most 46 (64.8%) participants who reported that the services were not available had low level of knowledge on SRHRs. Availability of RHS and level of knowledge on SRHRs had no statistical relationship (p=0.422). Majority 49 (69.0%) of the participants who reported that the RHS were not affordable had low level of knowledge on SRHRs. Affordability of reproductive health services and level of knowledge on SRHRs had a significant statistical connection (p=0.901).

Majority 31 (55.4%) of the respondents who cited that the attitude of healthcare providers did not influence their access to health services had high level of knowledge on SRHRs. There was an association between attitude of healthcare provider influencing access to reproductive health services and level of knowledge on SRHRs (p=0.001). Further findings pointed out that most 40 (71.4%) of the participants given information before provision of services had high level of knowledge on SRHRs. There was an association

between being given health information before initiating services and knowledge level on SRHRs (p=0.012). During a KII session one director narrated that:

"…Addressing issues of these people requires a lot of professionalism and also empathy. Negative attitude of health providers significantly affects the rate of utilization of services by them. When health professionals show positive attitude the youths with disability will want to get more information on SRHR and thus improve their knowledge level. Facilities that provide disability friendly youth reproductive services attract use of services and sharing of relevant information...."

Results disclosed that majority 37 (52.1%) of the respondents who reported that unfriendly physical infrastructure in the facility influenced access to reproductive health services had low level of knowledge on SRHRs. Unfriendly physical infrastructure and level of knowledge on SRHRs had significant statistical association(p=0.001). Majority 37 (66.1%) of the respondents who experienced long waiting time while accessing health services had high level of knowledge on SRHRs. Moreover, there was no significant statistical association between experiencing long waiting time while accessing health services and level of knowledge on SRHRs (p=0.056). Table 4.7 displays the findings:

Table 4.7: Relationship between health system factors and knowledge on RHR among participants (n=127)

Independent Variable	Participant response	Level of knowledge on SRHR		Statistical significance
		High (N=56)	Low(N=71)	
Ever used reproductive health services	Yes	27(48.2%)	5(7.0%)	χ^2=16.605 df=1 p=0.019
	No	29(51.8%)	66(93.0%)	
Disability is a hindrance to accessing reproductive health services	Yes	17(30.4%)	14(19.7%)	χ^2=18.475 df=1 p=0.001
	No	39(69.6%)	57(80.3%)	
Availability of reproductive health services	Yes	29(51.8%)	18(25.3%)	χ^2=1.725 df=2 p=0.422
	No	22(39.3%)	46(64.8%)	
	I cannot tell	5(8.9%)	7(9.9%)	
Affordability of reproductive health services	Yes	27(48.2%)	17(23.9%)	χ^2=0.208 df=2 p=0.901
	No	23(41.1%)	49(69.0%)	
	I cannot tell	6(10.7%)	5(7.0%)	
Attitude of healthcare providers influences access to health services	Yes	15(26.8%)	44(62.0%)	χ^2=46.792 df=2 p=0.001
	No	31(55.4%)	20(28.2%)	
	I cannot tell	10(17.9%)	7(9.9%)	
Given information before provision of services	Yes	40(71.4%)	24(33.8%)	χ^2=5.717 df=2
	No	11(19.6%)	32(45.1%)	

	I cannot tell	5(8.9%)	15(21.1%)	p=0.012
Unfriendly physical infrastructure in the facility	Yes	23(41.1%)	37(52.1%)	χ^2=15.134
	No	23(41.1%)	28(39.4%)	df=2
	I cannot tell	10(17.9%)	6(8.5%)	p=0.001
Experienced long waiting time while accessing health services	Yes	37(66.1%)	31(43.7%)	χ^2=8.814
	No	12(21.4%)	24(33.8%)	df=2
	I cannot tell	7(12.5%)	16(22.5%)	p=0.012

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CHAPTER FIVE: DISCUSSIONS, CONCLUSSIONS AND RECOMMENDATIONS

5.1 Introduction

Discussions, conclusions and recommendations on socio-demographic, awareness, and health system factors influencing level of knowledge on SRHRs in selected disability centres from Kisii County are presented in the section.

5.2 Discussions

5.2.1 Socio-demographic factors

The thesis aimed at determining socio-demographic characteristics affecting level of knowledge on SRHRs. The findings indicated that more than half of the participants were aged between 18-20 years. The results agreed with a research done in Ethiopia on SRH of impaired young individuals and reported that more than half of the participants were aged 20 years (Kassa *et al.,* 2014). The results further did not associated age with having a significant influence on level of knowledge on SRHRs among respondents.

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In a report on youth and sexuality, contrary results were also reported where age was associated with knowledge on SRHRs (Groce & Kett, 2014). This may be because advances in age means one gets to know and seek more information about his/her reproductive health rights coupled with use of such services thus increased level of knowledge. The results agreed with Renzaho et al. (2017) who did a study in a slum area in Kampala, Uganda on sexual, reproductive health needs and rights among people and found no significant statistical connection between age and knowledge level on SRHR.

Regarding participants' marital status, the findings disclosed that, of the participants, more than half were unmarried. This may be due to the fact that majority of the participants were in their school going age hence not married. It can further be justified by the fact that youth

with impairment starts their education at an older age thus affecting their marital status. Similar results were reported by Ayehu et al. (2016) who undertook a research in Awabel District in North-West Ethiopia and majority of the participants were single.

Marital status related significantly with level of knowledge on SRHRs among respondents. The results were in agreement with a study on SRHRs and impairment in humanitarian settings in Kenya, Nepal and Uganda where marital status significantly influenced knowledge on SRHRs (Tanabe *et al.,* 2015). This may be ascribed to the fact that when people are in a relationship or active sexually, they tend to seek more information as well as use RHS hence becoming more aware and thus knowledgeable on their reproductive health rights. Contrary findings were described by a survey done in Senegal on enablers and barriers to accessing SRHRs health services among young persons where there was no affiliation between marital status and level of knowledge on SRHRs (Burke *et al.,* 2017).

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Concerning the respondents' degree of disability, the study findings indicated that less than half of the participants were physically impaired. The results concurred with a survey done in Ethiopia on practice, attitude and knowledge on SRHRs among young persons with disability which disclosed that majority of the participants had impaired mobility (Kassa *et al.,* 2016). Contradictory findings were reported by Burke et al. (2017)) in their investigation carried out in Senegal where majority of the participants were visually impaired. However, there was an association between degree of disability and level of knowledge on SRHRs among respondents. This may be because individuals who are disabled are seen as outcasts and face almost similar challenges in regards to accessing reproductive health services thus limiting their knowledge level.

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The findings disclosed that most of the participants were male. The results were contradicted to Burke et al (2017) study where majority of the participants were female. In another study done in India on adolescent health, similar results were also reported, most of the participants interviewed were male (Sivagurunathan *et al.,* 2015). Gender and level of knowledge on SRHRs did not have any statistical significant relationship. As a matter of fact, majority of male respondents had high level of knowledge on their RHR. This could be because they outnumbered their female counterparts significantly affecting their knowledge levels. The results concurred with a study done in USA on sexuality of young people with intellectual and developmental disability where it was reported that women were disproportionately affected and neglected in terms of their reproductive health rights (Ballan & Freyer, 2017).

Regarding the respondents' religion, it was disclosed that majority the participants were Christians. This is because majority of people in the region where the study was done as per their demographic distribution are Christians. In a study done in Tanzania on accessibility to SRHRs education among marginalized youths in selected districts, similar results were reported where majority of the respondents were Christians (Ngilangwa *et al.,* 2016). Religious leaders represent a vital role in dissemination of SRH information during church sessions. Religion and level of knowledge on SRHRs did not have any association. The results were contrasted with a research done in Ethiopia where religion significantly influenced the level of knowledge on SRHRs (Aderemi *et al.,* 2014). This may be due to religious and cultural barriers, especially in the Muslim denomination where use of contraceptives is highly prohibited thus affecting their level of knowledge.

Regarding the number of children, one had, it was revealed that most of the respondents did not have children as majority of the respondents were single hence not sexually active. This may also be coupled by the fact people with disabilities are seen as outcasts hence

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are neglected by others who may not take them as their sexual partners. The results differed with a study in South Africa on SRHRs information where majority of the respondents interviewed had children (Waldman & Stevens, 2015).

There existed significant statistical connection between having children and knowledge level on SRHRs. In fact, majority of those who did not have children had low level of knowledge on SRHRs. This means that they did not use much of the reproductive health services neither did engage actively in sexual activities. The results were in agreement with studies done on access to SRH services among people with impairment and reported an association between the children number and level of knowledge on SRHR (Dossa *et al.,* 2014).

Regarding type education training one was involved in, the findings disclosed that more than half of the respondents were involved vocational trainings. In low income countries, people with disabilities do not go for normal education programs due to structural incapability which hinders them from accessing basic education (Schalet *et al.,* 2014). This therefore gives room for enrolment in vocational training as revealed by the study results. There was a statistical association between education involved in and level of knowledge on SRHRs. This is because in vocational training, as much as people tend to focus more on specific training courses other life issues such as SRHRs are also taught. The results concurred with a study by Pan *et al* (2015) where education was significantly associated with level of level of knowledge on SRHRs.

Regarding the breadwinner of those interviewed youths with disability, the results showed that the breadwinner was the father. This is because fathers are the sole providers of families especially in rural areas where most families rely on them. There was a connection between breadwinner and knowledge level on SRHRs. This may be attributed to the fact

that children tend to command more respect from those they think takes care of them as compared to others in the society. The results were similar to a study done in Senegal where it was revealed that parents were the sole breadwinners of youths with disability (Kasser *et al.,* 2016). In another study done by Seng *et al* (2019), contrary results were reported where it was shown that partners to people living with disability were their breadwinners. Disagreeing findings were also recorded by a survey done in Addis Ababa in Ethiopia, among visual and mobility impaired youths where it was revealed that the same individuals were their own breadwinners (Nigusie, 2016).

5.2.2 Knowledge on SRHRs

The study aimed to find out knowledge on SRHRs among respondents. The outcome of the survey disclosed that the participants were knowledgeable on them having a right to plan and establish a family. This would be explained by the fact that even those who are disabled have a constitutional right to marry and start a family in a mutual agreement between the couples. The results differed with Shiferaw et al. (2014) who did a study in Debremarkos town in North West Ethiopia on youths' talking about SRH matters with parents and affiliated characteristics among students of secondary and preparatory institutions and reported that they were not learned on their entitlement to design and build up a family.

As indicated by an examination done on the impacts of early relationships in Sub-Saharan Africa, opposite outcomes were accounted for where the respondents met were not have right information on their entitlement to design a family where young ladies are constantly compelled to early relationships without thinking about their assent (Delprato et al., 2017). In another research done in India among young people, the outcomes agree with the current investigation where the respondents had right information on their entitlement to design a family (Sivagurunathan *et al.,* 2015). Consistent results were also described on a research

conducted on sexual and experience of individuals with impairment in low- and middle-income countries where it was revealed that they were aware on their right to join in matrimony and plan a family (Carew *et al.,* 2017).

Regarding on the issues with terminating a pregnancy, the results showed that majority of the participants had wrong knowledge. This attributed to the fact that there are controversies surrounding termination of pregnancies as per the terms of the Kenyan constitution which might have been wrongly interpreted. According to another study, it was shown that young women are pressurized by families and healthcare professions to terminate their pregnancies hence they must fight for their right not to have an abortion. This means that they were not knowledgeable nor aware on their rights with regards to pregnancy termination thus similar to results of the current study (Campbell, 2017). On a study done on experience as knowledge: disability and decision making where contrary results were reported with respondents interviewed not being knowledgeable (Boardman *et al.,* 2017). According to a study done in Zimbabwe, it was revealed that many countries have had laws that ban women with impairment from getting pregnant and giving birth thus interfering with their rights to keep pregnancies (Peta, 2017).

Regarding on the individual rights to contraceptive usage, the outcome found out that more than half of the participants were not knowledgeable on their right to contraceptive usage. This may be ascribed to the fact that people with disability are neglected and barred from accessing RHS as they are not seen to be active sexually. The results concurred with a research conducted by Schaafsma *et al* (2017), who revealed that the respondents had wrong knowledge on their right to contraceptive use. In another study done on contraceptive decision making and women with learning disability, similar results were also reported as decisions on contraceptive use were often made by other people rather than by women with disability themselves thus unaware of their right to using

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contraceptives (Ledger et al., 2016). Dissimilar findings were also established by a research on young people with mental impairment speaking about sexual information and education, where the respondents interviewed were knowledgeable about their right to contraceptive use (Frawley & Wilson, 2016).

The study further attempted to determine whether the respondents were knowledgeable on their right to getting taught about sexual education in public schools, the results indicated that majority of the participants were knowledgeable as the study was done in disability centres, form of public institutions where there is available information on sexual education through health talks and sharing of information. The results were differed with those of study undetaken in Ontario, Canada where it was disclosed that youth with impairment do not receive the necessary comprehensive sex education (East & Orchard, 2014). In another study done on sexual education and intellectual disability, it was shown that most individuals with intellectual disability are not knowledgeable about their right to access information on their sexuality (MacDaniels *et al.,* 2016).

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The findings disclosed that most of the respondents were not knowledgeable on their right to accessing reproductive health services whenever they needed them. This may be due to the fact that most people think that accessing reproductive health services is privilege. People are not exposed to credible sources of information regarding their sexuality as most of them think that issues to do with sexuality is a private matter. The results were similar to a research undertaken on impediments to healthcare services for individuals living with disability in developing nations where it was revealed that majority of the respondents had an improper understanding on their right to access reproductive health services (Baart & Taaka, 2017; Hunt *et al.,* 2017). Deficiency of fundamental information and pressure from partners has scared off people living with impairment from accessing and utilizing RH

services in Ethiopia (Ayehu *et al.,* 2016). Another study report inconsistent finding where it was revealed that individual with impairment have also their right to accessing reproductive health services just like other people (Addlakha *et al.,* 2017).

Regarding the respondents' overall knowledge towards RHR, the findings revealed that majority of the participants had low knowledge on SRHRs. This may be attributed to barriers in accessing information on sexual education reduced levels of knowledge among respondents. The results echoed those of a research done in Ethiopia where it was revealed that the participants had low knowledge levels on SRH (Kasser *et al.,* 2016). In another study done on sexual health knowledge of people with mental disability, contrary results were disclosed where it was shown that there was high knowledge among people with disability but on average, they have a range of shortages in knowledge when compared to non-disabled individuals (Borawska-Charko *et al.,* 2017).

5.2.3 Awareness on RHR

The research endeavored to ascertain if the participants were aware of their reproductive health rights. The outcomes uncovered that most participants had at any point known about their SRHRs. This might be on the grounds that SRH is a touchy issue which is constantly been examined across an assortment of gatherings. This perhaps clarifies why most of the respondents knew about their regenerative wellbeing rights. The outcomes were predictable with an investigation done in Ethiopia on SRH of crippled youngsters where it was accounted for that dominant part 64.6% of the respondents knew about their SRHRs (Kassa et al., 2016).

Comparative outcomes were likewise detailed by another investigation in Tanzania where the level of awareness on SRHRs was at 55.1% meaning the respondents were aware of their SRHRs (Ngilangwa *et al.,* 2016). Contrasting findings were also established in a

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research conducted on women with disabilities in accessing SRH demands in Zimbabwe where majority of respondents were not aware on their SRHRs (Rugoho *et al.,* 2017). Contrary findings were established by a research carried out on SRHRs in India where majority of the respondents had low awareness which led to people with disability facing numerous challenges in access to SRH services (Dean *et al.,* 2017).

The level of awareness had an important statistical association with level of knowledge on reproductive health rights. This means that as one is exposed to information on their SRHRs, the more they are made knowledgeable of their rights. The findings concurred with a study done on access to SRH services in Ethiopia where awareness played a key role in increasing knowledge on SRHRs (Ayehu *et al.,* 2016). In another study done in Cambodia, it was shown that low knowledge had led to unattained need for SRHRs (Gartrell *et al.,* 2017).

Concerning the origin of information on SRHRs, the study disclosed that most of those who were mindful of their SRHRs, had heard it from media. This may be attributed to the fact that nowadays most information are shared through social and mass where access to information is easily available. The findings were similar to a study by Kasser *et al* (2016), which reported that majority of the participants revealed their main sources on SRH information was from radios and televisions. The findings differed with a study done on knowledge of SRH of people with bodily disability in Vietnam where the main source of information was in the schools (Nguyen *et al.,* 2018).

There results were different from those of a research done on SRHRs knowledge where it was shown that peer education was the chief source of information on SRH information in Tanzania (Ngilangwa *et al.,* 2016). Contrary outcomes were also disclosed by a study in Zimbabwe on challenges facing women with impairments in accessing SRH services

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where majority of the participants stated that the chief source of information on SRH education was the church (Ruguho *et al.,* 2017). There was no important association between source of information on SRHR and knowledge level on SRHRs. This may be attributed to the fact that the main source of information was media which targets a mass population and people don't tend to take it as a trusted source of information. Contradictory findings were disclosed by a survey done in Lahore District of Pakistan where parents as poor sources of information to adolescents at the family level affects their sexual and reproductive health growth (Iqbal *et al.,* 2017).

5.2.4 Health system factors

The research attempted to determine whether the participants had ever utilized reproductive health services. The results revealed that most had not used RHS. This could be supported by the fact that majority of the respondents were single hence not sexually active leading to low usage rates of reproductive health services among youth. The findings were similar to an investigation done on usage of SRH services among people with physical disability where under-utilization of services affected their sexual life (Nguyen *et al.,* 2016).

There was an important statistical connection between usage of RHS and level of knowledge on SRHRs with majority of those who had not used reproductive health services having low knowledge level. The findings were similar to a study on claiming SRHRs where usages of reproductive health rights was associated with knowledge on SRHRs (Addlatha *et al.,* 2027). In fact, through utilization of such services, individuals stand at a better chance to understand the services they get are what they need. In a study done in the Philippines on SRH services for women with disability, the results indicated that people recognized their rights but had lower utilization of SRH services (Lee *et al.,* 2015).

The results further indicated that majority of the participants disclosed that RHS were not available to them. This could be explained by the fact that the research was conducted in a school setting rather than a health facility thus probably majority of the participants had not looked for such services. The results were consistent with a study done on adolescents with impairment on their clinical demands in RH care where it was noted that lack of awareness on availability of RH services affected the level of knowledge thus consequently affecting their utilization rates (Quint, 2016).

However, accessibility of reproductive health services and level of information on SRHRs do not relate statistically. In another investigation done in Ghana on difficulties ladies with incapacity face in getting to and using maternal health care services, availability of RH services affected the level of knowledge on reproductive health rights among those interviewed (Ganle *et al.,* 2016). Perceived hindrances for health services access among persons with impairment in 4 African nations indicated that terrain and distance to health facilities affected availability of reproductive health services (Eide *et al.,* 2016).

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Regarding affordability of reproductive health services, most of the participants indicated that RHSs were expensive to them. This is due to reason that majority of the participants had not used reproductive health services hence did not know the true cost of such services. The results were concurred with a study done in Durban South Africa on access to SRH services where SRH services were provided with high costs hence not affordable to people with disability (Mavuso & Maharaj, 2015). There was no significant statistical connection between affordability of RHS and level of knowledge on SRHRs. The results were contrary to a study on efficient strategies to provide adolescent SRH services where it was noted that reducing costs increases demand for RH services thus increasing access to and awareness on RH services (Denno *et al.,* 2015).

Regarding the attitude of health care providers, the findings noted slightly less than half of the participants disclosed that the healthcare provider’s attitude influenced access to RH services. This is because poor attitude from healthcare providers means that patients may shy away from seeking such services due to unfriendly welcome. Similar findings were reached by a study on medical care suppliers' conduct towards incapacity and experience of ladies with handicaps in the utilization of maternal medical services in rural Nepal where negative attitude discouraged use of SRH services (Devkota *et al.,* 2017). Attitude of healthcare provider and level of knowledge on SRHRs related statistically significant as patients may refuse to use subsequent services. The results concur with another study done in Ghana, where it was reported that healthcare providers’ insensitivity has a positive influence on utilization of reproductive health services (Ganle *et al.,* 2016).

The result from this research revealed that 50% of the respondents get information before the provision of medical care administrations. Information provision implies that they were in a superior situation to realize that a portion of the services they got they were qualified for them as a component of their conceptive wellbeing rights. There was a critical factual relationship between being given data before administration and level of information on SRHRs. Steady outcomes were likewise detailed by different examinations where it was noticed that arrangement of data to young people builds their use rates on regenerative wellbeing administrations accordingly getting more mindful and learned on their privileges in youth-accommodating focuses (Mosavi *et al.,* 2014 and Temmerman *et al.,* 2014). Absence of admittance to data is an obstacle to looking for regenerative wellbeing administrations among individuals living with inabilities according to an investigation on SRHRs of girls and women with handicaps (Frohmader and Ortoleva, 2014; Atuymabe *et al.,* 2015).

Concerning the physical infrastructure of health facilities, the results disclosed that slightly less than half of the participants indicated that unfriendly physical infrastructure affected reproductive health services access. Some of the barriers indicated included unavailability of ramps and not enough healthcare providers who were able to understand the Kenyan sign language for communication and lack of interpreters. Consistent results were disclosed by a study in Nepal, Kenya and Uganda where wheelchair availability, sign language use significantly affected access to RH services among people living with impairment (Tanabe *et al.,* 2015). Unfriendly infrastructure and level of knowledge on SRHRs had a statistical significant association. The results were consistent to a study in South Africa and noted that medical infrastructure should be developed and provided to incorporate the unique needs of people living with disability (Gichane *et al.,* 2017). This would in turn improve the accessibility and thus increased knowledge on reproductive health services.

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Finally, the results disclosed that majority of the respondents disclosed that they experienced long waiting time while accessing health services. Waiting time influences access to services as people may feel tired before receiving services and therefore shy off. The results echoed those of a research undertaken in Democratic Republic of Congo, where long waiting time in a violent set up influenced utilization of RH services. This means that individuals were unable to enjoy reproductive health services as part of their rights (Ivanova *et al.,* 2018). In Ethiopia, long waiting time meant clients missed reproductive health services as they tired off in long queues before they were received assistance (Ayehu *et al.,* 2016).

In another investigation carried out in Ghana, Uganda and Zambia on HIV services accessibility for persons with disability living with HIV, it was noted that women did not want to wait in queues because other responsibilities were awaiting them (Tun *et al.,*

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2016). Further findings disclosed that experiencing long waiting time while accessing health services and level of knowledge on SRHRs showed a statistical significant association. Therefore, access to health services might have been affected by other factors like cost and accessibility of services in terms of distance rather than waiting time. In another study done on factors influencing utilization of teenage antenatal care in John Taolo Gaetsewe district in Northern Cape Province in South Africa, it was reported that long waiting time led to women not going for all the required ANC and increased chances of home deliveries (Worku *et al.,* 2016).

5.3 Conclusions

The thesis makes a conclusion that that majority of socio-demographic factors significantly influenced knowledge level on SRHRs among youths with disability in Kisii County. They included; marital status, degree of disability, having children, education involved, breadwinner and breadwinners' occupation.

The study further concludes that there was low knowledge levels on SRHRs in disability centres in Kisii County. This was despite high levels of awareness as the respondents were unable their SRHR as use of contraceptives and access to sexual education.

The study revealed that more than half of the participants in disability centres in Kisii County were aware on their RHR. The core information source concerning RHR was media. The source of information and awareness significantly influenced knowledge level on SRHRs.

The study finally concludes that most of the health system factors such as ever used SRH services, disability being hindrance, attitude of healthcare providers, given information, unfriendly physical infrastructure and experienced long waiting time significantly influenced the level of knowledge on SRHRs. There were low utilization rates of SRHRs.

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5.4 Recommendations

5.4.1 Recommendations from the study

i. The research recommends that the Kisii County government along with different partners in wellbeing engage young people with incapacity to begin income generating projects to build their access to financial for reproductive health services thusly improving their insight on SRHRs.

ii. The government, County government of Kisii and the stakeholders of disability centres should ensure scaling up of education and sensitization campaigns on SRHRs among people with impairment to raise their knowledge levels.

iii. Reproductive wellbeing rights activists, strategy makers and healthcare providers should increase advancement messages focusing in RHR awareness to contact underestimated individuals particularly YWD and those in difficult to arrive at territories.

iv. The government, county government of Kisii and disability centres should ensure there are adequate provision of youth friendly services in facilities with favorable environments for YWD and build capacity for provision of information on SRH as well as motivate the staffs providing care thus increase service utilization rates.

5.4.2 Recommendations for further study

i. A further research to be done to ascertain quality of SRH services among Youths with Disability in selected disability centers in Kisii County, Kenya.

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APPENDICES

Appendix i: Informed consent form

Background

My name is **Christine Obaga**, a post-graduate student at Kenyatta. I am conducting a research on **awareness on sexual and reproductive health and rights among youth with disability in selected disability centres of Kisii County, Kenya.** The aim of the study is to determine the respondents' awareness on reproductive health rights among youth with disability in selected disability centres so as to increase their awareness on practicing their reproductive health rights.

Procedure to be followed

The study is being carried out at selected disability centres in Kisii County. Participation in this study will require I ask questions and record it on a questionnaire for later analysis of the information provided.

Participation of the study is entirely on a voluntary service basis. You are free to withdraw or decline to participate at any point of the study. Your decision to participate or not in this study will not have any influence in your normal activity.

Discomforts and risks

There are no risks identified to you as a participant. Most of the questions asked may not cause much discomfort but if you feel uncomfortable in answering the questions then you may refuse to answer and stop the interview at any time. The interview will take 30 minutes to respond to the questionnaire if you agree to be a participant in the study.

Benefits

There will be no benefits rewarded but the research findings will help in improving awareness on reproductive health rights among women of reproductive age.

Reward

Participation to the study will be on voluntary basis and therefore no payments or compensation will be offered to those who agree to participate.

Confidentiality

As a participant, a study number will be given so that your name does not appear in any of the data collection instruments, and your name identity remains confidential. Only the team observers will know the number given to you. The questionnaires will be kept in a lockable file cabinet in the personal possession of the researcher.

If you have questions and contact information

You can ask me any question concerning the research. If you have any questions later you may contact Christine Obaga on 0720456149, Prof Margaret Keraka on 0721817521, Dr. Casper Masiga on 0724513406 or the Kenyatta University Ethics Review Committee Secretariat/Chairperson on kuerc.chairman@ku.ac.ke , kuerc.secretary@ku.ac.ke.

Participant's statement

I have read the consent form provided by a member of research group and volunteer to participate in the study. I have had an opportunity to ask questions about it and I have been answered to my satisfaction.

I accept to participate to this study at free will.

Signature/thumb print of participant …………………… Date……..........................

Investigators statement

I have explained to the volunteer in a language she understands the procedure to be followed in the study and the benefits and risks involved.

Signature of researcher ……………………… Date ……………………………….

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Appendix ii: Questionnaire

Please complete all the sections of the questionnaire and

Use (x) to select your options.

Questionnaire Serial no.______________ Date __________________

Name of interviewer____

DEMOGRAPHIC FACTORS

1. Age	2. Marital status	3.Degree of disability
a) 15-17 b) 18-20 c) 21-23 d) 24 and over	a) Single b) Married c) Other, specify………………….	a) Blindness b) Deafness or a severe hearing impairment c) Physical impairment d) An intellectual disability e) A psychological or emotional condition f) Chronic illness g) Other, please specify …………………………… …………………………… 4. Gender …………………… 5. Religion a) Christian b) Muslim c) Other (specify)……………

6). Who is your breadwinner?
a) Father
b) Mother
c) Other (specify)____

7. What is your breadwinner's occupation?
a) Civil servant
b) Farmer
c) Business person
d) Other (specify)____

8. Have you got any children [of any age]?

a) Yes
b) No

9. What education are you currently enrolled?
a) Vocational
b) Rehabilitation

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c) Normal curriculum
d) None

Awareness factors

10) Have you heard about sexual and reproductive health rights?

a) Yes
b) No

11) Where did you learn about sexual and reproductive health rights? Check all

a) From a friend
b) parents/relatives
c) media
d) A health provider.
e) Health talks
f) Other (specify)____

Knowledge factors

12) Which sexual and reproductive health rights do you know (in matters regarding to SRHR) check all

a) Individual's right to plan a family,
b) Issues with terminating a pregnancy,
c) Use of contraceptives,
d) Learn about sex education in public schools,
e) Gain access to reproductive health services.
f) Other, specify ……………………………

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13) Tick whether right or wrong

Statement	Right	Wrong
I am allowed to plan a family		
I can decide on the fate of my pregnancy		
I can decide on when to use a family planning method		
I belief in sex education being taught in schools		
I can access reproductive health services whenever I need them		

Health system factors

14. Does your disability hinder you from accessing reproductive health services? ....

15. If yes, explain………………………………………………………………………

16. A Have you used any of the reproductive Health services…………….

17) If yes, where did you get the services?

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a) Youth friendly clinics
b) Public hospital
c) Private hospital

18) Were you accompanied to seek services? ....

19) If yes, why were you accompanied? ....

20) What challenges did you face accessing the SRHR services?

STUCTURES	Tick where appropriate
a) Lack of rumps on infrastructure	
b) No interpreter(s)	
c) No materials in braille	
d) No wheelchairs	
e) unfriendly health providers	
f) cost	

g) Other, specify………………………………..

21) What can you do if your sexual and reproductive health and rights are violated?

a) Report to the teachers/program guides
b) Report to the local authority
c) Report to the police
d) Other, specify……………………………………

22) What measures can be taken to prevent the violation of sexual and reproductive health and right in the future among the disabled youth? ………………………… ………………………………….

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Appendix iii: Focus Group Discussion Guide

1. What do you understand about SRH?
2. a) Do you know of any SRH services offered to young people?
   b) Which services do you know?
3. a) What do you understand about SRHR?
   b) List any SRHR you know.
4. Which sexual and reproductive health services and programs offered to young people have you used?
5. What is the knowledge and attitude of young people In regard to reproductive health information and services?
6. a) What are the channels to accessing SRH information and services among the youth?
   b) What are the barriers to accessing SRH information and services?
7. c) What are the challenges to accessing SRH information and services
8. Who are the key stakeholders in the community influencing YWD on reproductive health issues?

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Appendix iv: Key Informant Guide

1. a) Who are the key stake holders at institutional levels including government, non-governmental organisations , civil society organisation and donor work on YWD's health and policy issues
   b) What is the role of each one of them?
2. What are the gaps in addressing YWD sexual and reproductive health programs and rights?
3. What are the challenges in addressing YWD sexual and reproductive health programs and rights?
4. How can YWD RH services and policies be improved

Appendix v: Research authorization from Kenyatta University Graduate School

KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 020-8704150

Our Ref: Q139/CE/26171/2014 **DATE: 4th February, 2019**

Director General,
National Commission for Science, Technology and Innovation
P.O. Box 30623-00100
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION FOR MS. CHRISTINE KWAMBOKA OBAGA – REG. NO. Q139/CE/26171/2014

I write to introduce Ms. Christine Kwamboka Obaga who is a Postgraduate Student of this University. She is registered for M.P.H. degree programme in the **Department of Population, Reproductive Health & Community Resource Management.**

Ms. Obaga intends to conduct research for a M.P.H. thesis Proposal entitled, **"Assessment of Access to Sexual and Reproductive Health and Rights among Youth with Disability from Selected Disability Centres of Kisii County, Kenya."**

Any assistance given will be highly appreciated.

Yours faithfully,

PROF. ELISHIBA KIMANI
DEAN, GRADUATE SCHOOL

Appendix vi: Ethical clearance from KU Ethics and Review Committee

KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Fax: 8711242/8711575
Email: chairman.kuerc@ku.ac.ke

Website: www.ku.ac.ke

P. O. Box 43844,
Nairobi, 00100
Tel: 8710901/12

Our Ref: KU/ERC/ APPROVAL/VOL.1 (267)

Date: 14th June, 2019

Christine Kwamboka Obaga
P.0 Box 43844-00100
Nairobi

Dear Ms. Obaga

APPLICATION NUMBER PKU/996/I1046: ASSESSMENT OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AMONG YOUTH WITH DISABILITY FROM SELECTED DISABILITY CENTRES OF KISII COUNTY.KENYA

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic "**Assessment of Access to Sexual and Reproductive Health and Rights among Youth with Disability from Selected Disability Centers of Kisii County. Kenya**" ". Received on 21st March, 2019 and discussed on 14th May, 2019

2. APPLICANT

Christine Kwamboka Obaga

3. SITE

Kisii County. Kenya

4. DECISION

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines and **APPROVED that the research may proceed for a period of ONE year from 14th May, 2019.**

5. ADVICE/CONDITIONS

i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
ii. Serious and unexpected adverse events related to the conduct of the study are reported to this committee immediately they occur.
iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.
If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.

PROF. JUDITH KIMIYWE
CHAIRMAN ETHICS REVIEW COMMITTEE

KENYATTA UNIVERSITY
OFFICE OF THE CHAIRMAN
26 JUN 2019
ETHICS REVIEW COMMITTEE
P.O. BOX 43844 - 00100 NAIROBI

I...CHRISTINE OBAGA.........accept the advice given and will fulfill the conditions therein.

Signature............................. Dated this day of....26th June.......... 2019.

cc.

DVC-Research Innovation and Outreach

Appendix viii: Research permit from NACOSTI

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014.

CONDITIONS

1. The License is valid for the proposed research, location and specified period.
2. The License and any rights thereunder are non-transferable.
3. The Licensee shall inform the County Governor before commencement of the research.
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
5. The License does not give authority to transfer research materials.
6. NACOSTI may monitor and evaluate the licensed research project.
7. The Licensee shall submit one hard copy and upload a soft copy of their final report within one year of completion of the research.
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice.

National Commission for Science, Technology and innovation
P.O. Box 30623 - 00100, Nairobi, Kenya
TEL: 020 400 7000, 0713 788787, 0735 404245
Email: dg@nacosti.go.ke, registry@nacosti.go.ke
Website: www.nacosti.go.ke

REPUBLIC OF KENYA

National Commission for Science, Technology and Innovation

RESEARCH LICENSE

Serial No.A 26380

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MS. CHRISTINE KWAMBOKA OBAGA
of KENYATTA UNIVERSITY, 0-100 NAIROBI,has been permitted to conduct research in Kisii County

on the topic: ASSESSMENT OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AMONG YOUTH WITH DISABILITY FROM SELECTED DISABILITY CENTERS OF KISII COUNTY, KENYA

for the period ending:
19th August,2020

Permit No : NACOSTI/P/19/56231/31779
Date Of Issue : 22nd August,2019
Fee Recieved :Ksh 1000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation

Appendix ix: Research authorization from Kisii County

REPUBLIC OF KENYA
MINISTRY OF EDUCATION
State Department of Early Learning and Basic Education

Telegram: "EDUCATION"
Telephone: 058-30695
Email address: cdekisii@gmail.com
When replying please quote

REF: CDE/KSI/RESECH/89

COUNTY DIRECTOR OF EDUCATION
KISII COUNTY
P.O. BOX 4499 - 40200
KISII.

DATE: 26TH August , 2019

Christine Kwamboka Obaga
Kenyatta University
P.O Box Box 43844-00100
NAIROBI

RE: RESEARCH AUTHORIZATION.

Following your research Authorization vide your letter ***Ref. NACOSTI/ P/19/56231/31779*** to carry out research in Kisii County, this letter refers.

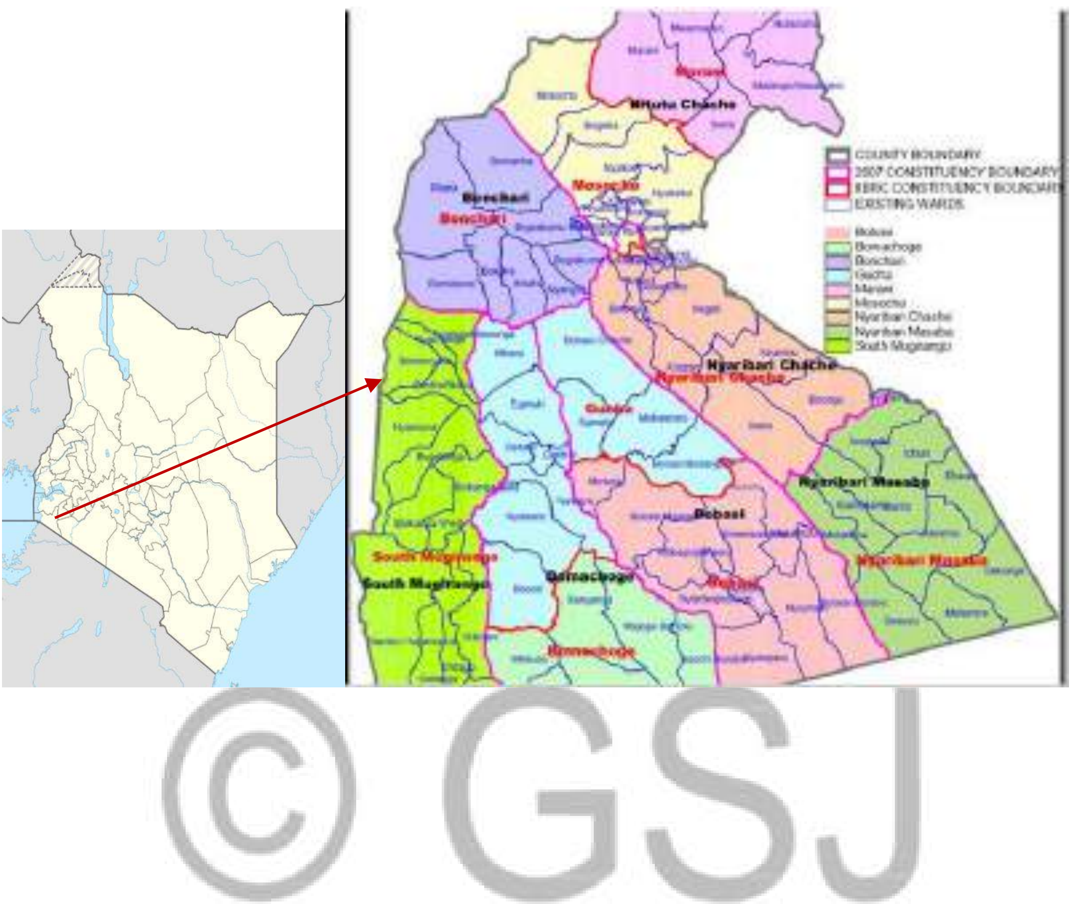
I am pleased to inform you that you can carry out your research in the County on ***"Assessment of access to sexual and reproductive health and rights among youth with disability from selected disability centers in Kisii County, Kenya"*** for a period ending, ***19th August 2019.***

Wish you a successful research.

COUNTY DIRECTOR OF EDUCATION
KISII
P.O. Box 4499-40200 KISII

Pius Ng'oma
County Director of Education
KISII COUNTY.

Appendix ix: Map of Kisii County



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