



Patterns of Reproductive Health among Women with Disabilities (AS80)

An Analysis Brief from The DHS Program

Why study disability and reproductive health?

The sexual and reproductive health needs of people with disabilities have been neglected in research, policy, and practice and are poorly understood as a result. Compared to women without disabilities, do women with disabilities have disadvantages or advantages when it comes to accessing health care and achieving their reproductive health goals? To what extent? Where? Regarding which health outcomes? This study is one of the first multi-country analyses of disability and multiple reproductive health outcomes. It aims to fill the research gap on reproductive health needs of women with disabilities in low- and middle-income countries (LMIC).

Which countries are included in the study?

This analysis includes data from nine Demographic and Health Surveys (DHS) conducted since 2010 which included standardized disability measures. These surveys were conducted in Haiti, Mali, Nigeria, Pakistan, Rwanda, Senegal, South Africa, Timor Leste, and Uganda.

What methods were used to conduct this analysis?

In 2015 The DHS Program established a standard optional module on disability, adapted from the Washington Group Short Set of questions on functional limitations. It covers six domains: vision, hearing, communication, cognition (remembering and concentrating), mobility (walking or climbing steps), and self-care (washing all over and dressing). The respondent to the household questionnaire provides information on all *de facto* household members age five and above. Each person's ability to function in each domain is classified on a 4-point scale as: no difficulty, some difficulty, a lot of difficulty, or cannot perform task/function at all. In this analysis, a person with disability is a person who has a lot of difficulty or cannot perform the function at all in at least one domain.

This study uses both bivariate (cross tabs with chi-square tests of independence) and multivariable regression analysis to investigate the association between women's disability status and 10 health outcomes (see box).

Is disability status associated with access to health services and reproductive health outcomes?

Reproductive ideation and sexual behavior

- Fertility desires (want another child within 2 years)
- Ideal number of children
- Recency of sex (in the past month)

Health care access

- Difficulty accessing health services
- Had 4+ antenatal care visits
- Facility delivery

Contraception and pregnancy

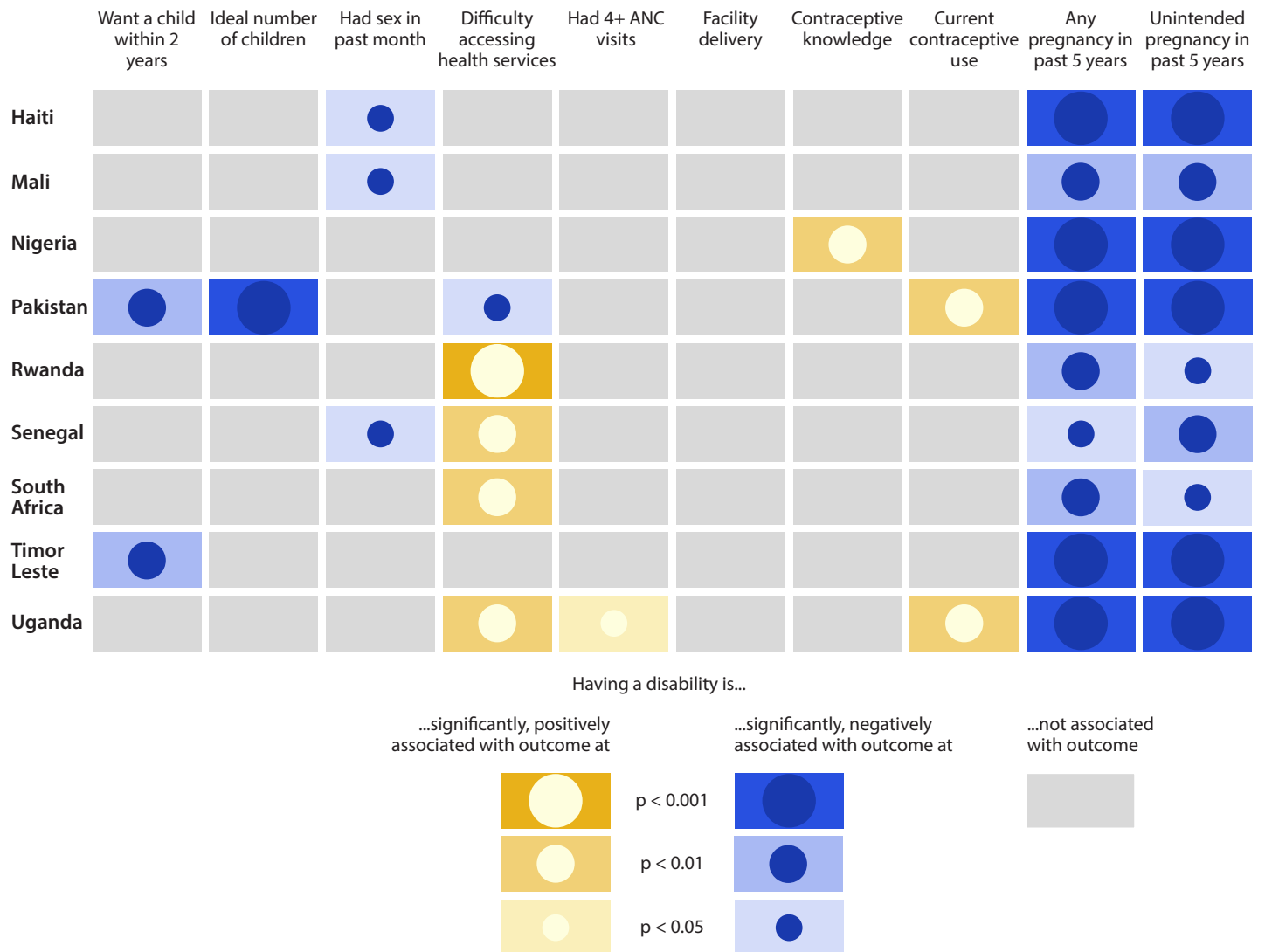
- Contraceptive knowledge
- Current contraceptive use (any method)
- Pregnancy
- Unintended pregnancy

What are the key results?

Women with disabilities are not consistently disadvantaged across all health outcomes.

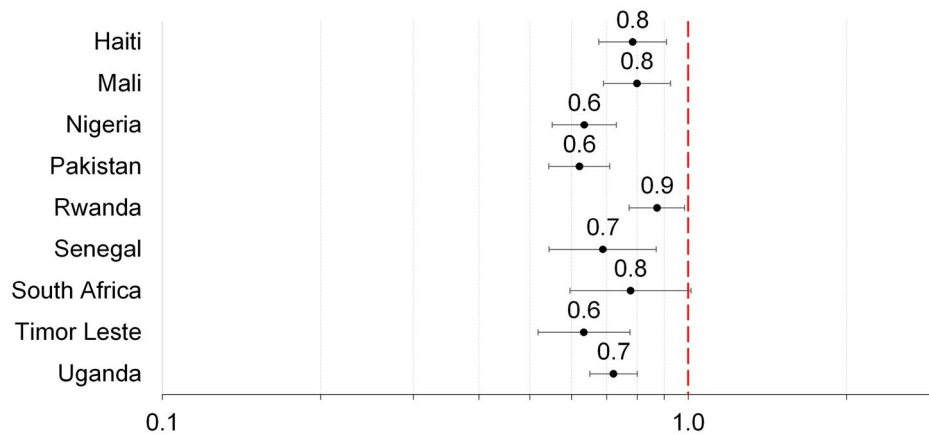
Figure 1 summarizes the findings by country across 10 health outcomes. In most countries women with disabilities are similar to women without disabilities in terms of their fertility intentions, sexual activity, and use of antenatal care and facility delivery, and contraceptive knowledge, as shown in grey boxes. For some outcomes, associations with disability status are sporadic and vary by country. Women with disabilities have a lower ideal number of children than women without disabilities in Pakistan, and women with disabilities have greater contraceptive knowledge in Nigeria than women without disabilities.

Figure 1. Summary of associations between having a disability and study outcomes.



Women with disabilities have better outcomes in some areas. Namely, having a disability is associated with less unintended pregnancy in all study countries. In multivariable logistic regression models, women with a disability have lower odds of experiencing unintended pregnancy than women without disabilities, ranging from 10% lower odds in Rwanda to 38% lower odds in Pakistan. Results are borderline not significant in South Africa (Figure 2). In all study countries, women with disabilities also have lower odds of experiencing any pregnancy in the last five years, a neutral outcome.

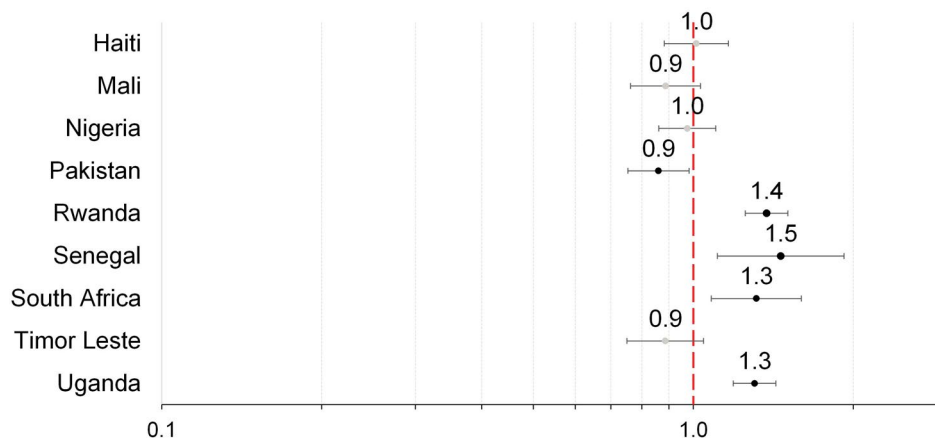
Figure 2. Association of having a disability with experience of unintended pregnancy in the past 5 years. Odds ratios from separate multivariable logistic regressions. Since the horizontal line representing the confidence interval for South Africa crosses the vertical dotted red line, the results are borderline not significant.



Note: Models control for age, education, household wealth quintile, marital status, and parity.

There are still some areas of concern for women with disabilities. In four countries (Rwanda, Senegal, South Africa, and Uganda), women with a disability experience significantly higher odds of having difficulties accessing health services than women without disabilities (Figure 3). In Pakistan, women with a disability are less likely than women without disabilities to experience these difficulties.

Figure 3. Association of having a disability with experiencing big problems seeking medical advice or treatment when sick. Odds ratios from separate multivariable logistic regressions. If the horizontal line representing the confidence interval does not cross the vertical dotted red line, women with disabilities have significantly different odds than women without disabilities of experiencing problems seeking medical advice or treatment when sick.



Note: Models control for age, education, household wealth quintile, marital status, and parity.

This study also explores contraceptive method mix. Although women with disabilities have similar or (in Pakistan and Uganda) greater odds of using contraception compared to women without disabilities, the method mix differs according to disability status.

Figure 4. Among women using any contraception, percent of women using female sterilization by disability status.

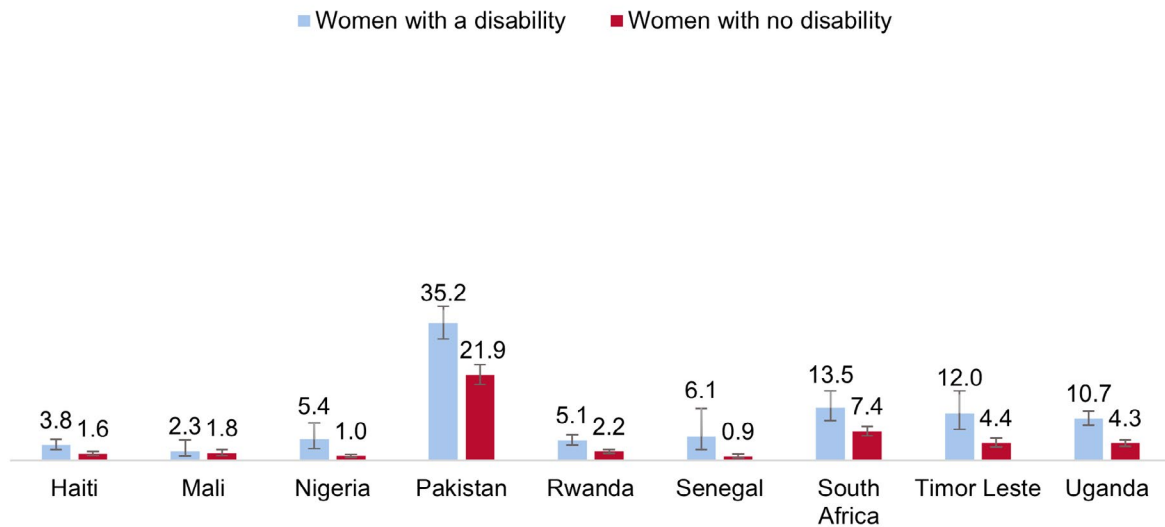


Figure 4 shows the differences in female sterilization among women using any contraception by disability status, the method with the most striking and consistent differences. In every country but Mali, women with disabilities are significantly more likely to be using female sterilization than women without disabilities. Female sterilization ranges from two percentage points higher among women with disabilities in Haiti to 13 percentage points higher in Pakistan.

What does this mean?

This study does not find compelling evidence of widespread, systematic disadvantage or poorer health outcomes for women with disabilities across all countries, for all outcomes. Instead, disability status is only consistently associated with pregnancy and unintended pregnancy across all nine study countries. For other outcomes, differences by disability status are sporadic across countries.

It is a concern that women with disabilities face more difficulties accessing health services in four countries and are more likely to be using female sterilization in eight countries. This may reflect fundamental differences in contraceptive preferences, but it could also indicate that women with disabilities are unable to fully exercise informed choice if health providers are steering women with disabilities to certain methods. Further analyses of disability and reproductive health outcomes can assist health systems to continue to expand availability and improve quality of reproductive health services for all clients, including those with disabilities.