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Assessment of Challenges of Disabled Women Towards Accessing Medical Health Care Services in Addis Ababa Ethiopia; A Qualitative Study -2022Gc

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Abstract

Background-*. A disability may be defined as the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, and developmental, and some combination of thesethat result in a restriction on an individual's ability to participate in what is considered "normal "intheir society (1). Studies indicate that women with disability face a lot of barriers in accessing maternal healthcare services.*

Objective of the study *-to assess the challenges of women with disabilities in accessing maternalhealth care services. Barriers to accessing maternal and major interventions were explored in detail.*

Methods- a *qualitative study based on grounded theory tradition has been conducted in two study areas from May-01/2021- to September -15/2021 in 7 health care facilities and three disability associations (blind association, hearing and deaf associations, and physically impaired association) in Addis Ababa, Ethiopia. Two data collection methods were used. Practical site observations and in-depth interviews were used at the disability associations at seven healthcare facilities and three governmental Minister Offices. Method triangulation and data triangulation were carried out. A conceptual framework has been established based on the data collected about the challenges women with disability face in accessing maternal healthcare services. Microsoft Word andMicrosoft Excel were used for data analysis.*

Results *-From the observation, it was revealed that the infrastructures in the health care service are not conducive for people with disability. There are no ramps or elevators in most healthcare facilities, and there are trained sign language interpreters who display wall-mounted information regarding maternal health. The laboring tables and examination beds were fixed. From thein-depth interview, participants reported that they faced discrimination and negative attitudes from health providers, and negative attitudesfrom the community were also significant challenges that they had to bear.*

Conclusion *In general, the study found that women with disability face a lot of challenges in accessing maternal healthcare services. The lack of infrastructure was a significant problem.*

Recommendation *-health providers, health institutions and different stakeholders should work incollaboration to provide a quality healthcare service and meet the needs of women with disability.*

Keywords: *Assessment, Challenges, Disabled, Women, Accessing Medical Health Care, Sexual Reproductive health*

1. Introduction

1.1. Background

A disability may be defined as the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, and developmental, and some combination of these that result in a restriction on an individual's ability to participate in what is considered "normal "in their society [1]. Across the world, people living with disabilities have poorer health outcomes, lower education achievements, less economic participation, and higher rates of poverty than people without disabilities. This is partly because people living with disabilities experience barriers in accessing services that many of us have long taken for granted, including health, education, employment, transport as well as information. These difficulties are exacerbated in less advantagedcommunities. WHO report stated that half of people living with disabilities cannot afford health care, compared to a third of people living with no disabilities. People living with disabilities are morethan twice as likely to find healthcare providers' skills inadequate. People living with disabilitiesare also four times more likely to report being treated badly and nearly three times more likely to be denied health care [2]. Using survey data from 2015/16, almost 7.8 million people in Ethiopia are estimated to live with some form of disability or 9.3 percent of the country's total population. Of these, up to 2.2 million people (2.4 percent) have profound difficulties [3].

A qualitative study that was done in Nepal regarding healthcare providers' attitudes towards disability indicates that a lack of disability-specific Knowledge, discomfort working with people with disabilities, and misconceptions about disability held by healthcare providers are the issues contributing to providers' negative attitudes that are a formidable barrier to healthcare services by women with disabilities. These attitudes and misconceptions are often subtle. For example, women with disabilities may not be asked about contraceptives, or healthcare providers might defer a pelvic exam due to the misconception that women with disabilities are generally sexually inactive. Disability issues, care, and management are rarely included in medical school, nor are they usually appropriately addressed in public health and health system management training, particularly in low and middle-income countries. Studies show that while some medical schools in high-income countries now include disability issues in curricula to improve students' Knowledge, attitude, and skills in disability care, it is still not a priority [4].

A study that was done in Ethiopia regarding communities' attitudes towards intimacy, pregnancy, and motherhood of WWD depicts that in most developing countries and also in a few developed countries, there was a long-time deep-rooted belief in the community that women with a disability should not perpetuate and start relationships, this marginalized segment of people are particularly vulnerable to socially constructed misconceptions, regarding the impossibility and inability of being involved in relationships and experiencing pregnancy and motherhood. In some cases, women with disabilities may get pregnant due to sexual abuse. Sexual violence is a profound human rights violation and public health concern. Disabled mothers are often viewed as incapableof handling a maternal role; they are in many ways denied children and derided as mothers [5].

1.1.1. Maternal health care situation in Ethiopia

USAID 2020 report on maternal, neonatal, and child health indicates that ensuring timely arrival and service quality at facilities would lead to better maternal and child health, but this remains a challenge. These conditions are exacerbated as the health system struggles to meet the demand for routine quality healthcare and frequently needs to respond to drought, conflict, or disease outbreaks, including COVID-19 [6]**.** A study that was done in Ethiopia on the reasonsfor persistently high maternal and perinatal mortality indicates that it is primarily due to delays. These three main delays are the major contributors to perinatal and maternal death in Ethiopia. These delays impact both women with disabilities and abled-bodied women, but they affectmore vulnerable groups like people with disabilities due to their condition. The second Delay is in getting access to a health facility once the decision is made at home to seek medical care in one ofthe accessible health facilities; the third Delay in receiving medical care is failure to detect obstetric problems timely and taking action, including Delay in referral and delay in consultation, arealso among the significant issues in the health care system, Of these factors, shortage of well-trained health workforce takes the lion's share for the Delay in providing the medical care for those who have access to a health facility [7].

YPWD in Ethiopia, as in other developing countries, have an increased risk of SRH-related problems, as they are more likely than the general population to be illiterate, unemployed and impoverished. They often lack equal access to information and education for reasons ranging fromphysical access to classrooms and service areas to varied special learning needs. Values and attitudes of others and their decisions about what education or information to provide also play a Significant role. There is also a lack of practical, youth and disability-friendly, and easily accessible information related to sexuality and relationships for YPWD. In addition, there is a lack of positive, open, and respectful spaces for YPWD to discuss disability and sexuality/relationship issues. Lack of access to training and educational programs, in turn, hinders the development of qualified personnel. Very little has been done concerning disseminating information and public awareness campaigns to improve public attitudes about persons with disabilities. These issues exacerbate this group's problems, making them vulnerable to different types of SRH-related problems like STI/HIV, unwanted pregnancy, or unsafe abortion [8].

1.2. Statement of the problem

A Study done in Ireland and the United Kingdom to assess Dignity and respect duringpregnancy and childbirth shows that only 19% thought that reasonable adjustment or accommodation had been made for them; when reasonable adjustment was not in place, participants' independence and Dignity were undermined, and more than a quarter of women felt they were treated less favorably because of their disability [9].

In developing countries, women, in general, are subject to social, cultural, and economic disadvantages that impede their access to education, rehabilitation, labor protection and health care because of cultural preferences for males; it is seen as a waste of resources to help disabled women become productive members of society. In addition, if they are physically or mentally disabled,their chances of overcoming their disablement are diminished, which makes it all the moredifficult for them to take part in community life [10].

Unmet needs during pregnancy among women with physical disabilities include clinical Knowledge and attitudes, physical accessibility of health care facilities and equipment and need for information related to pregnancy and postpartum support [11]. Despite all the legal provisions and institutional arrangements in place, the attainment of the rights of persons with disabilities remains a significant concern. The Ethiopian Human Rights Commission and the institution of the Ombudsman have the mandate to monitor the rotation and advancement of human rights in the country. However, the government's capacity and technical expertise to monitor implementation must be improved [12].

Women with disabilities in Ethiopia face various barriers in accessing health information communication and services; there are no provisions in the health posts to accommodate the needs of women with disabilities in terms of transportation, priority access, or infrastructure, and stigma against women with disabilities is still very predominate in society amongst service providers especially if they are HIV positive; the result of this is a very hostile atmosphere that makes PMTCT and other services les accessible to women with disabilities[13]. Deaf pregnant women face a challenge in accessing SRHR services. They faced obstacles in both family planning services (including access to contraception). In receiving good services during prenatal care and delivery, medical personnel refused to assist the deaf patient either when a sign language interpreter was present due to privacy or when a sign language interpreter was not present [14].

Health facilities are primarily designed with no consideration for PWDs. As a result, accessibility toSRH services like prenatal and postnatal care, services and information related to HIV/AIDS, and family planning services are not met. Pregnant mothers with hearing impairment face difficulties communicating with health professionals as there are no sign language interpreters in the health care facilities and those who are accompanied by friends and families to assist them; this affects their privacy and confidentiality. Those with visual impairments face difficulties maneuvering around the health facilities and getting the service. For pregnant women with a physical impairment who use wheelchairs, Crutche s face a massive problem as there are no elevators in most healthcare facilities. Furthermore, the roads that are built in health care facilities are not construed well, taking into consideration those with disabilities. Healthcare and healthcare education are often not supportive of disabled women. Sexual education often is absent [5]. It is challenging for a disabled, pregnant woman to get a medical card, as they are ignored as a person because Doctors avoid direct contact with them. [5] Most health professionals disapproveof the pregnancy of disabled women; the women had to suffer while waiting until they received proper treatment

1.3. Justification of the study

Many studies conducted in low-income countries show that people with disabilities face numerous challenges in accessing maternal healthcare services. However, in our county, there were only a few studies done regarding the challenges that women with disability face in accessing maternalhealthcare services in our country, and most of them were studied with different methodologies.

So, the goal of this study is to learn about the lived experience that women with disabilities face when seeking maternity health care services in Ethiopia.

1.4. Significance of the study

Only a few studies have been conducted in Ethiopia on the difficulties experienced by disabled women in obtaining maternity health care. As a result, this research will contribute to a modestbut increasing body of empirical research findings in low-income countries like ours.

This research will benefit healthcare professionals such as doctors, midwives, and other healthcare professionals who provide maternal healthcare to people with disabilities. It will help them be aware of what is expected of them and can provide health care without judgment, discrimination,or carelessness.

The findings will provide a valuable indicator for disability-related organizations and non-governmental organizations to participate in providing technical expertise in the delivery of acceptable healthcare to women with disabilities. They will also direct the areas where changes and modifications are needed, particularly in maternal healthcare.

Furthermore, this study will aid healthcare facilities such as health centers, hospitals, and ambulance service providers in providing compassionate, caring, and respectful care to pregnant women with disabilities.

2. Literature Review

Infrastructure

A survey of the experience of disabled women and a qualitative study that was conducted in rural and urban communities in the BOSOMTWE and Central GONJA districts of Ghana suggest that although women with disability do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled care, as well as gain access to unfriendly physical health infrastructure. Other related access challenges include healthcare providers' insensitivity and lack of Knowledge about the maternity care needs of women with disability, negative attitudes of service providers, the perception from non-disabled persons that women with disability should be asexual, and health information that lacks specificity in terms of addressing the special maternity care needs of women with disability [15].

A study that was done in Scotland, in which disabled women experience and utilization of maternity services while affected by abuse, indicates that even though women and their babies are entitled to equal access to high-quality maternity care. However, when women fit into two or more categories of vulnerability, they can face multiple, compound barriers to accessing and utilizing services. Disabled women are up to three times more likely to experience domestic abuse than non-disabled women. Domestic abuse may compromise health service access and utilization, and disabled people, in general, have suboptimal access to healthcare services. Despite this, little is known about the compounding effects of disability and domestic abuse on women’s access to maternity care. Positive staff attitude and empowering women to control their care are crucial in influencing women’s access to and utilization of maternity healthcare services. Moreover, these are cyclical, with the consequences and outcomes of healthcare use becoming part of the enabling or disabling factors affecting future healthcare decisions [16].

A phenomenological study in the Philippines to assess the challenges of WWD indicates that women with disability are those women with impairments that can be either physical, sensory, cognitive, or mental, which can affect everyday life activities. Pregnant women with disability, for instance, experience challenges during pregnancy. Their voices of being

mothers are heard from different perspectives. This study aimed to explore the maternity care experiences of women with disability. The result of this study shows women with disability experience a range of challenges in realizing their rights to maternal care. The women have positive and negative.

Accessing maternal services during their pregnancy to delivery period was difficult for them. They did not fully enjoy some privileges. Strong disability support was needed to increase their autonomy and not feel a burden of care. The findings on maternity care experiences of women with disabilities have clinical and research implications. The participants know the barriers and facilitators of care for having disabilities [17].

A study that was done in Nepal to assess the accessibility of healthcare services for vulnerable groups, women with disabilities, reported that vulnerable groups like people with disabilities have less access to healthcare. The distribution of health facilities was found to be uneven and poorly linked with road transport facilities. None of the health facilities accommodated the needs of women with disabilities with accessible buildings and convenient opening times. The travel cost and the extra cost of services, staff shortage, often delays, and inadequate drug supplies were common problems for both women with and without disabilities. Unavailability of beds during delivery, insensitive providers with negative attitudes and abusive behavior, inadequate Knowledge and experience in providing services to people with disabilities, and an unwelcoming health facility environment made services particularly inaccessible to women with disabilities [18].

A review of maternal health experiences and challenges of women with physical disabilities shows that WWPD faces multiple challenges facing WWPD were identified, including low self-esteemand confidence, negative responses and lack of family support, problematic experiences oftransport, health and other social systems for maternal healthcare of WWPD, and social unacceptance and discrimination from the community. Addressing barriers to accessing healthcare services was perceived as an individual responsibility of WWPD and their families rather than a perception that society had an obligation to act. The reproductive [18] rights of WWPD, particularly the expression of sexuality and the right to motherhood, need to be conceptualized beyondindividual responsibility. Society needs to eliminate attitudinal and environmental barriers to ensure WWPD can choose to be mothers without the threat of discrimination or negative social consequences [19].

A study that was done in Uganda Kampala indicates that despite the universal right to access thesame range, quality and standard of accessible or affordable health care and programs as provided to other persons, people with physical disabilities (PWPDs) continue to experience challenges in accessing these services. The study findings show that PWPDs face a multitude of challenges in Accessing SRH services includes negative attitudes of service providers, long queues at health facilities, distant health facilities, high costs of services involved, unfriendly physical structures, and the perception from non-disabled people that PWPDs should be asexual [20].

A systemic review on barriers facing women with disability in accessing reproductive health indicated that there is evidence that persons with disabilities often encounter grave barriers whenaccessing sexual and reproductive health services. To the best of our knowledge, however, no systematic review has been conducted to gather these pieces of research evidence to understand the nature, magnitude, and extent of these barriers in different settings in sub-Saharan Africa. We do not yet have a good understanding of the strength/quality of the evidence that existson the barriers persons with disabilities face when accessing sexual and reproductive health services in sub-Saharan Africa. Persons with disabilities face a myriad of demand and supply-side barriers to accessing sexual and reproductive healthcare in sub-Saharan Africa. Multilevel interventions are urgently needed to address these barriers [21].

A qualitative study that was done in district Uganda indicated that women with walking disabilities had psychosocial, mobility, special services, and personal needs. Psychosocial needs include accepting partners, communities, families, and health workers. Mobility needs were associated with transport unsuitability, difficulty finding transport, and heightened transport costs. Health facility needs included infrastructure and responsive health services, while personal needs included personal protective wear, basic needs, and birth preparedness items [22].

A thematic Literature review that was done in 11 countries on barriers to PWD in developing countries showed that there appeared to be seven main barriers - 4 related to the demand side, i.e., about the individual seeking healthcare services, and three barriers to the supply side, i.e., about healthcare provision. These are 1) Lack of information, 2) Additional costs of healthcare, 3) Limited mobility, 4) Stigmatization on the demand side while on the supply side, 5) Staff attitude, 6) Communication barriers, and 7) Inaccessible facilities. Stigmatization and marginalization are significant barriers to accessing healthcare services. These are primarily embedded in negative family and community attitudes toward people with disabilities, leading tofeelings of rejection, shyness and lack of confidence [23].

A study that was done in Bahirdar, Ethiopia, showed that visually impaired women were active seekers of SRH information (knowledgeable about SRH information and understanding the relevanceof accessing such information) and passive recipients of SRH information (through formal and informal sources). However, some contextual factors (lack of family and caregiver support services) created barriers for visually impaired women when accessing SRH information. Government advocacy and awareness campaigns on SRH services should consider formal and informal sources. Family caregivers and SRH health centers should provide adequate support services for visually impaired women regarding information on SRH services [24].

A study that was done in our country to assess the reproductive health of young people with disability indicates that similar findings are common in developing countries; in Ethiopia, young people with disabilities (YPWD) are more likely than the general population to be illiterate, unemployed and impoverished. They often lack equal access to information and education for reasons rangingfrom barriers regarding physical access to services to varied special learning needs. Only 64.6 % of YPWD were aware of SRH services. Radio and TV were mentioned as the primary sources of information by 62.2 % of the participants. 77.9 % had never had a discussion about SRH topics with their parents. Even though 96.7 % of the respondents had heard about HIV, 88 % had poor Knowledge about ways of preventing HIV. Perception of the risk of getting infected with HIV wasfound to be generally low in YPWD; only 21.6 % believed that they were at risk of acquiring HIV [8].

A study that was done in Arbaminch, Ethiopia, regarding modern contraceptive use and associated factors indicates that the magnitude of unmet need for family planning among women with disabilities was 24.3%. Women with disabilities in the age group of 25 - 29 are 80% less likely tohave unmet needs than women above 35 years old. Women with disability who have no educationwere 11 times more likely to have unmet needs than those who have secondary education. Womenwho desire to have more than three children are more likely to have unmet needs than those who needto have 1 or 2 children. The unmet need for family planning among women with disabilities was high in Bahir Dar town. Age, Educational status and desired number of children were found to have statistically significant associations with unmet need for family planning. This study revealed that unmet need is specifically high among women aged 35 years and above, about 67.5% [25].

A -sectional study that was done in Gonder, Ethiopia, regarding modern contraceptive use andassociated factors among WWD indicates that about 18% of participants had ever used modern contraceptives and the contraceptive prevalence rate among study participants and currentlymarried women was 13.1% and 20.2% respectively. One-fourth of respondents believed that existing family planning service delivery points were inaccessible. The proportion of modern contraceptive use among participants was low. Age, marital status, education, income, and type ofdisability were significant predictors of modern contraceptive use. Therefore, social and behavioral change communication interventions should be designed to improve the awareness of people living with disabilities on modern contraceptives based on the needs and type of disabilities [26].

A cross-sectional survey that was done in our country on modern contraceptive methods Knowledgeand practice in Blind and deaf women in Ethiopia showed that nearly two-thirds of the respondents were sexually active. Most (97.2%) of the study respondents had heard about FP methods. However, the comprehensive Knowledge of modern contraceptive methods was 32.5%. The prevalence of unwanted pregnancy was 67.0%, and abortion was 44%. Almost half of the sexually active respondents ever used modern contraceptive methods, yet the contraceptive prevalence at the time of the survey was 31.1%. Implants were current users' most commonly used (51%) contraceptive method. Service providers and program managers do not grasp the relevanceof their work and interventions in addressing the sexual and reproductive health needs of women with disabilities [27].

2.1. Health provider's attitude

A Study done in Ireland and the United Kingdom to assess Dignity and respect duringpregnancy and childbirth shows that only 19% thought that reasonable adjustment or accommodation had been made for them. When reasonable adjustment was not in place, participants' independence and Dignity were undermined, and more than a quarter of women felt they were treated less favorably because of their disability [9].

A study that was done in Nepal regarding health provider's attitudes towards WWS indicates thatWomen with disabilities are less likely to receive maternal healthcare services compared to womenwithout disabilities. While few studies have reviewed the healthcare experience of women with disabilities, no studies have been conducted to understand providers' attitudes towards disability inNepal, yet the attitudes and behaviors of healthcare providers may have a significant influence on Aspects of care and the use of service by women with disabilities. This study examines healthcareprovider's attitudes towards disability and explores the experience of women with disabilities in maternal healthcare service utilization during pregnancy and childbirth. The majority of qualitative interview participants perceived providers to have a negative attitude with poor Knowledge, skills and preparation for providing care to persons with disabilities. Few participants perceived the providers as kind, respectful, caring or helpful [4].

In a qualitative study that was done in the Philippines, an analysis of service providers' accounts suggests a range of factors undermine the provision of high-quality sexual and reproductive health services to women with disability. Service providers often have limited awareness of the sexual and reproductive health needs of women with a disability and an inadequate understanding of their rights. Service providers have had very little training about disability and limited access to the resources that would enable them to provide a disability-inclusive service. Some service providershold discriminatory attitudes towards women with disability seeking sexual and reproductive health services, resulting in disability-based discrimination. Service providers are also often unaware of specific factors undermining the health of women with disability, such as violence and abuse. Women in the Philippines continue to report barriers to sexual and reproductive health services, and there is limited empirical evidence available to inform policymakers' efforts to respond. This study aims to contribute to the available evidence by examining service providers' perceptions of disability and their experiences providing sexual and reproductive health services to women withdisability [28].

A study that was done in Nepal indicates that all groups, women with disabilities and women without disabilities, Dalit and non-Dalit, rated their perceptions and experiences of quality of care lowly in several items. While the perceived quality of care between women with disabilities andwithout disabilities in the 'Health Facility' dimension and associated items were found to differ ($p<0.05$), this difference was linked to disability status but was not linked to caste differences. Forexample, differences in mean scores relating to 'Cleanliness and Facilities,' 'Open and Friendliness,' and 'Compassion and Kindness' were highly significant ($p<0.001$), with women withdisabilities rating these as better than women without disabilities. On the other hand, women without disabilities rated the 'Availability of cash Incentives' more highly ($p<0.01$). No significant differences were found between Dalit and non-Dalit women in perceived quality of care, except in Regarding 'Cleanliness and facilities,' which Dalit women rated lower than non-Dalit ($p<0.05$), Perceptions about the quality of care differed significantly by disability status [29].

A study was done to assess reproductive health and disability in humanitarian settings: risks,needs, and capacities of refugees with disabilities in Kenya, Nepal, and Uganda. Shows that refugees with disabilities demonstrated varying degrees of awareness around SRH, especially regarding the reproductive anatomy, family planning, and sexually transmitted infections. Amongthe barriers to accessing services was the lack of respect from providers, which was reported as the most hurtful. Pregnant women with disabilities were often discriminated against by providers and scolded by caregivers for becoming pregnant and bearing children; marital status was a significant factor that determined if a pregnancy was accepted. Risks of

sexual violence prevailed across sites, especiallyfor persons with intellectual impairments. The ability of women with disabilities to exercise their SRH rights was mixed. Refugees with disabilities showed a mixed understanding of their rights in relationships and the pursuit of opportunities. A more significant number of refugees with disabilities and their caregivers in Kenya and, especially, Uganda complained about challenges in accessing health services. Harmful and disrespectful provider attitudes were reported as the most influential barrier that deterred refugees with disabilities from accessing services [30].

2.2. Community attitude

A study that was done in Ghana to assess childbearing desires and motivations among women with disabilities shows that nearly all the WWDs interviewed were sexually active, desiring to have children, and intended to have as many children as they could support. Strong desire to experience the joy of motherhood; fear of social insecurity, fear of old age, and economic insecurity; desire to challenge stigma and negative stereotypes about disability, sexuality and motherhood; and desire for self-actualization were critical motivations for childbearing. Our findings challenge existing negative public perceptions about the status of WWDs regarding sexuality, childbearing and motherhood. More importantly, our findings suggest that if the Sustainable Development Goals related to universal access to sexual and reproductive healthcare are to be attained, WWDs must be targeted with quality sexual and reproductive healthcare information andservices [31].

The rights of Ethiopia's disabled have been quashed or ignored for millennia. Generations have grownup in a society shaped by Religions and their dogmas, which construes disability as the result of Sin is a source of shame. Whether the disability is physical or cognitive, regardless of an affected person's courage and capacity to cope, the disabled have been excluded from many aspects of Ethiopia's disabled can hope for charity at best, but at worst, may be hidden from neighbors, drivenfrom their homes, and forced to beg to survive. They are the least employed, often the poorest. Politically, they are voiceless. Enacted laws and published policies have turned out to be wishful thinking or false promises. These are jabs at old wounds [32].

The study that was done in Ethiopia on the grace of motherhood on intimacy, pregnancy and motherhood showed that all of the interviews indicated that relationships and motherhood proved an advantageous option for women with disabilities. They also expressed their need for intimacyregardless of society's denial. Challenges identified include negative societal attitudes toward women with disabilities regarding relationships, pregnancy, and child-rearing. Accessibility of health centers, in addition to the ignorance and negative attitudes of the physicians, are also reported to be significant challenges for the interviewees. Society doubts their ability to be intimate and become wives and mothers [5].

Therefore, this study aims to assess the challenges of women in accessing maternal healthcare services among disabled women based on the following leading basic research questions.

- ✓ What are the significant challenges of women with disabilities in accessing maternal health careservices?
- ✓ What do they say about their experience in health care facilities, especially the attitude ofthe health professionals towards them?
- ✓ How do women with disability explain the lack of maternal health services?
- ✓ What do women with disability propose as an intervention to increase maternal healthservice?

3. Objectives

3.1. Major objective

- ✓ To assess the challenges of women with disabilities in accessing maternal health careservices.

3.2. Specific objectives

- ✓ To assess the main challenges of women with disabilities in accessing maternal health careservices.
- ✓ To assess the reasons for the lack of conducive maternal health care service for womenwith disabilities.

4. Methods

4.1. Study Area

The research was conducted in seven healthcare facilities in Addis Ababa and threedisability associations in Addis Ababa. Addis Ababa is the capital city of Ethiopia. And it'slocated at 9°1'48" N38°44'24" E/9.03000°N 38.74000°E. It lies at an elevation of 2,200 meters (7200ft) and is a grassland biome; its area covers 527 sq. km. The population density is estimated to be near 5,165 individuals per square kilometer. As of 2017, the population counts grew closer to4 million. It has a subtropical highland climate with precipitation varying considerably by the month and a complex mix of highland climate zones. There are 11 sub-cities in Addis Ababa. It's a hubfor administrative and non-governmental institutions and performs municipal functions. As of 2014, Addis Ababa had 52 hospitals; 12 were state-run, and more than 40 were privately owned. Around 41 disability-related public organizations and associations work with disabled people, and around eight disability-related aid projects have been established in Addis Ababa, Ethiopia. The estimated number of people with severe disabilities in Addis Ababa is around 47,000, and 324,000 in other urban areas of the country. (3, 33)

The seven selected health facilities were representative of governmental and private healthcare services. Yekatit 12 Hospital Medical College, ST. Paul's Hospital Millennium Medical College, and three health centers, Mikililand Health Center, Woreda 01 Health Center, and Janmeda Health Center and from private health care service, Grace MCH Specialty Center and Brass MCH Specialty Centers were selected as representatives of MCH service delivery provision institutions to all socialclasses of the community in Addis Ababa, Ethiopia. The three disability associations include the Ethiopian National Association of the Deaf (ENAD), The Ethiopian National DevelopmentAssociation of Persons with Physical Disabilities (ENDAPPD), and the Ethiopian National Association of the Blind.

4.2. Study Design and period

A qualitative study based on phenomenological research was conducted from May 01/2021 to September 15/2021, in seven healthcare facilities, including disability associations and three governmental ministers in Addis Ababa, Ethiopia. - Phenomenological research was selected as it describes the essence of the phenomenon of human being's lived experience, and this study wanted

Also, to explore the lived experience of women with disability in accessing maternal health care services. Phenomenology is the study of phenomena. Emphasize the researcher keeping in mind theories, frameworks and models; this process of clearing the mind is called "bracketing''so this research methodology

was in line with the study's objective and only with this methodology approach that the investigator could learn more about the study participants.

4.3. Population

4.3.1. Target population – all disabled women who gave birth at a health institution regardless of the birth outcome in Addis Ababa.

4.3.2. **Source population-** all disabled women who gave birth at a health institution regardless ofthe birth outcome and who are a member of disability associations

4.3.3. **Study population** -all disabled women who are in ANC, PNC or who delivered at health institution regardless of the birth outcome and who are a member of disability associations, three disability groups; - physical disability, visual impairment and hearing impairment.

4.4. Sample size determination and selection scheme

A purposive sampling technique was used. Sixteen in-depth interviews were conducted with six blind,six physically impaired and four deaf mothers at their respective disability associations. Sample size adjustment has been done in this research according to the information saturation obtained.The women who were included in this study were identified through screening at their respective disability associations. Women who gave birth five years ago and women who had an intellectual disability were excluded because of the complexities involved in assessing mental disability and partly because of the investigators' limited Knowledge in undertaking such assessment.

In-depth interviews were conducted with key informants of 3 disability associations' branch managers, and one was conducted with each head of branch disability association personnel.

In-depth interviews with administrators of three healthcare facilities, one from Yekatit12 Hospital Medical College, One from Mikililand Health Center and one from Janmeda Health Center, were selected after in-depth interviews with women with disability. The interviews with administrators of the health institutions were selected after sortingout information from the data collected, which helped the investigator select where most women we with disabilities, they went for their ANC, intrapartum and postpartum follow-ups. Then, three administrators from the seven healthcare facilities were selected for the interview.

Ten health professionals, six midwives and four gynecologists were interviewed in depth. The health professionals were selected after sorting out information from the data collected from women with disabilities. This helped the investigator select where most women with disabilities went for their ANC, intrapartum and postpartum follow-ups and dig out more information from different perspectives. Expert sapling selected the health professionals.

Focal personnel from governmental institutions were selected using a Purposeful sampling technique. Two interviews were conducted with focal personnel from the Ethiopian Ministry of Health, two interviews were conducted with focal personnel from the Addis Ababa health bureau, and two in-depth interviews were conducted with focal personnel from the Ethiopian Ministry of Labor and Social Affairs.

Forty practical site observations were conducted using an observational checklist in the selected seven healthcare institutions. These institutions represent healthcare facilities in Addis Ababa,serving all community spheres.

4.5. Eligibility Criteria

4.5.1. Inclusion criteria

The following eligibility criteria will be used to select the participants:

- ✓ Those pregnant and in the ANC_ Postnatal period had followe d up in healthinstitutions.
- ✓ Those who delivered in health institutions
- ✓ Women who gave birth regardless of the outcome (live or dead fetus) and those who losttheir neonate during postnatal included
- ✓ Must be a member of one of the disability associations in Addis Ababa, Ethiopia.

4.5.2. **Exclusion criteria**

- ✓ Women with disabilities who were not members of one of the disability associations inAddis Ababa, Ethiopia.
- ✓ Women with disabilities other than the five listed above, including Autism

4.6. Data collection procedures and quality assurance

Two main qualitative data collection methods were site observation and in-depth interviews. All the data was collected at Addis Ababa's seven HCFs, three disability associations, and three government institutions. The lead investigator was responsible for all site observations and in-depth interviews with key informants.

Interviews have been scheduled to coincide with the study participants' schedules. At three disability organizations, 16 in-depth interviews were conducted. Six interviews with visually impaired mothers, six interviews with physically disabled mothers, and four interviews with deafmothers were conducted at their respective disability organizations. The interviews continued untilthe investigator determined that the information was saturated. The participants' in-depth interviews were conducted in locations without sound interference with the audio recording. During the in-depth interview, semi-structured questions prepared in the participants' native language, Amharic, were utilized, and the interviews were audiotaped with the participants' permission for transcription, translation, and analysis. The interview with deaf mothers began with semi-structured questions being asked to their caregivers or family members, after which they were translated to her, and her response was translated back to the investigator. The interview was audiotaped. The field notes were utilized to evaluate transcripts and to assess the credibility and legitimacy of the narrative data during data analysis after the interview.

In-depth interviews were done in three locations to achieve the goal of data triangulation. A total of ten in-depth interviews with health providers were done at three of the seven healthcare facilities. Six interviews with midwives and four with gynecologists were done. In addition, three interviews were conducted with three healthcare institution administrators from the selected healthcare facilities. In addition, two interviews were conducted with experts in maternal and child healthfrom the Ethiopian Ministry of Health, two interviews with focal personnel from the Addis Ababa Health Bureau, and two additional interviews with focal personnel from Ethiopian Labor and Social Affairs. Appropriate fieldwork engagement, triangulation, clarifying researcher biases, and providing detailed descriptions during data collection and analysis were all

practiced. Triangulation of data and method triangulation was done to maintain the study's trustworthiness.

Forty practical site observations were conducted, and more observations and derivations were conducted at the ANC OPD examination room, labor wards, and other reproductive health areas in the seven healthcare facilities.

Five basic observations were made during the study, with two categories in ANC OPDs. The firstobservation was about the significant ANC service provided to WWD, blind mothers, physically impaired mothers, and deaf pregnant women. The third category involved observing the available trained professionals in sign language and possible communication channels and teaching materials for each type of disability. The third observation was to observe the various reproductive healthcare service areas, the fourth observation was to analyze the seven healthcare facility building layouts, and the final observation was to observe the seven healthcare facilities' atmosphere. Each health facility and OPD examination room was observed over several weeks and months to see whether there were any changes over time. The investigator considered the notion of making the topic matter comprehensive with a hidden objective. The non-participatory mode of observation was used to observe all ANC activities. All ANC service packages are observed; health professionals and clients know this. This wasdone to eliminate the possibility of participant bias.

During practical site observation, the exact topic was concealed, and the period was set between 8:00 a.m. and 12:30 a.m. when there was a high volume of client traffic. The principal investigatormeticulously filled out the observational checklist established for this purpose, and all significant events were captured during observation. Practical site observation was conducted in seven MCH specialty centers, totaling 20 ANC OPD examination rooms in Addis Ababa. The WHO-2016 ANC guidelines mentioned that the most critical ANC actions were checked during practical site observation.

A Pre-test has been conducted, one site observation at Guto Media Health Center and three in-depth interviews carried out at each disability association in Arada sub city were carried out in Addis Ababa.

4.7. Data Analysis

The written words taken during the semi-structured interview were compiled and incorporated with the recorded audio tape. After compiling the recorded Audio tape interview, It was transcribed into words using no verbatim transcription. Also, the keywords and expressions the respondent replied to were highly emphasized.

The data collected using sign language were interpreted and transcribed along with the audio recording for the analysis. The estimated ratio of time required for transcribing the interviews was about 6:1, meaning it took six hours to transcribe a one-hour interview.

After transcription, the next step was familiarization, which means reading all the parts, sorting out contradictory findings, words or metaphors, vivid expressions, repetitions, and gaps, and then coding.

During coding, developing a description from the data, defining themes from the data and identifying emerging themes, naming data, compiling them into groups and making a cluster; - those with the same characteristics were treated in one theme, and so on; then, identification of keythemes and concepts. After initial coding and thematic classification, the emerging themes developed to give conceptual classification. Data was collected until information saturation had been obtained. Data triangulations have been carried out throughout the research processes.

All observational checklists were analyzed using Microsoft Excel. The findings were displayedusing different methods, including tables. ATLAS TI software and Microsoft Excel were used whenever necessary. These two different methods enhanced the trustworthiness of the data by making appropriate coding and themes.

4.8. Ethical consideration

This research project was conducted, evaluated, and reported with these guidelines:respect for person, beneficence and non-maleficence, justice, and honesty were always maintained. This research was submitted to the institutional board of GAMBY Medical and Business College for ethical clearance. Ethical approval was taken from GAMBY Medical and Business College review committee and Addis Ababa Health Bureau; while conducting the practical observation and interview, an information sheet was given, and written consent was requested from theparticipants who can read and for blind mothers was read, and purpose of the study was explained. Participants were informed that they could withdraw at any time if they did not feel comfortable about the question, and the confidentiality of the study was presented, stating that theiridentity would not be exposed to third parties. Privacy and confidentiality were always met, and a written consent form will be shown or read to the participants.

5. Results

5.1. Observations

Table 2: Activities performed by health professionals during practical site observation inSeven HCF from May -September 2021 G.C

ACTIVITIES	Performances/ 40 observations	Percent of activities
Good Rapport with the mother maintained	35	83
Examination		
Fetal monitoring	40	100
Vital sign checked	40	100
The gestational age of the fetus calculated	40	100
Obstetric examination	40	83
Ultrasound checked	35	83

Weight of the mother checked	35	83
Urine and blood sample sent	34	80
Treatment		
Iron supplementation given	40	100
TT vaccination given	40	100
Treatment of disease given, if there is any	0	0
Counseling		
Counseling on ITN use	0	0
Discussion about substance intake during pregnancy	0	0
Counseling about eating a balanced diet during pregnancy	15	16.6
Counseling about specific exercises during pregnancy foreach disability type	0	0
Counseling about the impact of disability on pregnancy and the impact of pregnancy on disability discussed	0	0
Counseling about PMTCT/STI	25	50
Counseling about breastfeeding	30	66.6
Counseling about assistance /position/adaptive strategy during breastfeeding	0	0
Counseling about danger sign	30	66.6
Counseling about birth preparedness plan	0	0
Next appointments were told	40	100

We can see from the table that only a few activities and sessions were given regarding counseling,particularly in how to maintain optimum weight during pregnancy, ITN uses and prevention of STIs and prevention of mother to child HIV prevention, to people with disabilities, and that no counseling was given regarding exercise during pregnancy, for which type of disability which type of exercise is best practiced, and which type of exercise to be avoided. The 5 women with wheelchairs who came for ANC visits were not on the weight scale for measuring their weight. Duringtheir ANC visits, there was no counseling about the birth preparedness plan. Even though 66.6 % of women were counseled about breastfeeding, there was no specific advice about the needs for assistance, positioning, adaptive strategies like pillows to support wheelchair mothers, about adjustable height feeding chair for women with weak hand grasp were not addressed. And there was no discussion about the impact of disability on pregnancy and the impact of pregnancy on disability discussed. We can see from the above table the health providers main concern is fetal condition in general,danger signs to mothers and the next appointment of mothers were the main focus.

Table 3: Observation of available trained personnel and possible communication channel forWWD in Seven HCF during ANC service from May – September 2021 G.C

Communication channels				Observation	Percent
Available sign language translator				No available personnel	-
Available personnel in the ANC who could assist				No available personnel	
Brail format	Different maternal and child Health education topics			No	
Messages (broacher and pamphlets)	Stages of fetal growth			No	
Wall- mounted messages displayed insign language					
	Information related	regarding	nutrition	No	-
	Information about PMTCT			No	
Assistive devices				No	-

We can see from the table above that there was no trained sign language interpreter in all ANC service areas, that there were no displayed sign language messages and brochures regarding maternal and child health related topics for hearing impaired and deaf mothers, that there were no Brochures written in braille for visually impaired mothers, and that there were no assignedpersonnel who could assist physically impaired mothers and wheel chair users.

Table 4: Environmental Observation of communication channel in Seven HCFs at ANC/labor wards /from May – September, 2021 G.C

Channel of communication	Types of Messagedisplayed or transferred	Visibility from distant (>2.5 meter)
Wall mounted Chart	Stage of fetal growth	Visible
Wall mounted Chart	Emergency maternal condition management	Moderate
Wall mounted Chart	Clinical stage of HIV/AIDS	Less
Wall mounted Chart	2016 WHO ANC Model	Moderate
Wall mounted Chart	Syndromic diagnosis if STI	Visible
Wall mounted Chart	Mgso4 injection protocol	Moderate
Wall mounted Chart	Focus ANC periods	Less
Wall mounted Chart	Hand washing procedure	Visible
Wall mounted Chart	Family planning methods	Visible
Wall mounted Chart	Management of Convulsion	Less
Wall mounted Chart	Bishop score	less
Wall mounted Chart	Disinfection methods /Chlorine preparation	less
Brochures	Cervical cancer screening advantage	Visible
Brochures	Different topics	Visible
Notice boards	Different notices concerning staffs and clients	Visible

Majority of the communication channels were used were wall mounted channels and majority ofthe information displayed and transmitted were more understandable for women with no disabilitybut for WWD there is no sign language interpreted wall mounted charts or brochures made with braille.

Table 5: Observation of service areas of the seven health care facilities from May – September, 2021 G.C.

SERVICE AREA OBSERVATION OF THE 7HEALTH CARE FACILITIES		BEDS*	
		Fixed/Flexible	# Health care facility HCF)
Family planning service		FIXED	In all 7 HCF
Labor wards	Laboring bed	Both fixed and flexible	3/7 HCF
	Obstetric Delivery table	Fixed	In all 7 HCF
ANC Wards/PNC wards		Fixed /Flexible 3/7)	
Reproductive and Gynecological services case observation and performing rooms		Fixed	In all 7 HCF
Ambulance service		No ramps	In all 7 HCF

*reproductive and gynecologic care services- Gynecological services case observation andperforming rooms, Cervical cancer screening, adolescence RH and ultrasound rooms

*BEDS-Obstetric delivery Table/Postnatal beds /EXAMINATION BEDS, *HCF -Health care facilities

From the above table, observation of the 7 health care facilities service areas, we can see from theabove table, only in three health care facilities out of the seven had flexible beds, for laboring mothers who are on first stage of labor and for postnatal mothers in postnatal care unit. Also, in theobserved health care facilities there were no available flexible obstetric delivery table's. But in allother reproductive and maternal service areas the examination beds were fixed and immobile, which makes it especially hard for wheelchair users and physically impaired mothers during givingbirth. We can also see from the above table that in all HCFs, there are no ramps available inside the ambulances.

Table 6: Observation of the of the seven health care facilities buildings from May – September, 2021 G.C.

OBSERVATION OF THE 7 HEALTH CARE FACILITIES BUILDINGS	AVAILABLE /NOT AVAILABLE	FUNCTIONAL /NONE FUNCTIONAL	WIDE/MEDIUM/ NARROW SIZE	PIT LATRINE /SEATING HIGH TOILET SEAT /MEDIUM/LOW	
				separated	Communal
Building Elevators	4/7 HCFs	3/7HCFs			
Building Ramps	5/7HCFs (only goes to 1st floor)				
Building stairs			Medium in all 7 HCFs		
Corridors (hallways)			Medium 3/7HCFs Narrow 3/7 HCFs		
toilets	No separate toilet available			Seating toilet and communal toilet in all 7 HCFs	

*HCFs -Health Care Facilities

Observation of the construction arrangement of the seven health-care institutions. We can see, there are no separate bathrooms for people with disabilities. Only four of the HCFs have elevators, and only on three of them is operational. Additionally, only five of the seven health facilities havea ramp in the buildings, and the ramps only go up to the first level, and the building stairs and hallways are not broad enough to support PWD needs.

Table 7: Environmental observation of the compounds of the seven health care facilities from May – September, 2021 G.C.

Environmental Observation In 7HCFs	AvailableOr not	Separated Entry /No	ReadableOr not	Open/Closed	Asphalts or Cobblestone	Percent (%)
Walk ways					Asphalts 4/7 HCFs	57
Information desk	Available in 3/7 HCFs					43
Ditches				Open 4/7 HCFs		57
Separate gait entry		1/7 HCF				14
Direction sign board at the entry	Available in 3/7 HCFs		Readable 2/7 HCFs			43
Percent (%)			13			

*HCFs -Health Care Facilities

According to the above table, only four of the seven HCFs observed have well-constructed asphaltsinside their compound, and there were open ditches that were not closed in 4/7 HCFs. Only one ofthe seven HCFs has a separate gait entry for PWD, and only two of the four HCFs have readable and easily understandable displayed direction sign boards.

5.1. Interview participants

Participant	Age	Marital Status	Numberof Children	Educational Status	Types of Disability	Years in the Association	What They Useto Maneuver
Interview 1	30	Married	1	Degree	Physical Impairment	15	Crunch
Interview 2	32	Married	5	3rd Grade	Physical Impairment	10	
Interview 3	29	Married	1	Diploma	Blind	12	Cane
Interview 4	32	Married	Preterm death	MSC	Blind	15	Cane
Interview 5	36	Married	3	12th Grade	Blind	2 Weeks	Cane
Interview 6	28	Married	1	12th Grade	Blind	10	Cane

Interview 7	43	Single	1	-	Physical Impairment	12 Years Ago,	Nothing
Interview 8	34	Widow	1	College Student	Blind	10 Years	Cane
Interview 9	28	Married	1	Diploma	Blind	10	Cane
Interview 10	30	Single	1	No formal education	Physically Impaired	4	Crunch
Interview 11	37	Separated	5	10th Grade	Physically	2	Crunch
Interview 12	37	Married	2(4year)	Didn't Attend	Physically Impaired	4	Crunch/Stick
Interview 13	26	Married	1	Diploma	Deaf	5	-
Interview 14	28	Married	1	8th Grade	Deaf	6	-
Interview 15	32	Married	1	12th Grade	Deaf	8	-
Interview 16	30	Married	1	12th Grade	Deaf	5	-
Average	32		2			8	

The above table displays the characteristics of interview participants for health providers: 6 Midwives who had All BSC in Midwifery and an average experience of 6 years, all women; 4 gynecologists who were interviewed with an average experience of 5 years, one of whom was female.

Healthcare administrators were men. Two have degrees in public health officer, and one was an Internist. The branch head of the blind association was a woman with an MSC in special needs educationand ten years of work experience. The branch of the deaf association was male, and he had a BSC in specialneeds education with six years of experience. The physically impaired branch manager was male with five years of experience; he had a BSC in political science. All four focal personnel from the Ministry ofHealth and Addis Ababa health bureau were medical doctors; two had MSC in public health with an average of three years of experience. The branch focal personnel from labor and social affairs were male; one had an MSc in public administration with ten years of experience, and the other had a BSCin Leadership with 12 years of experience.

Most of the in-depth interview results are arranged in eight themes.

- Theme 1- Challenges to accessing healthcare facilities,
- Theme 2 -Healthcare provider's attitude towards women with disability
- Theme 3- Attitudes of Auxiliary Service Providers
- Theme 4 -Health care infrastructure as experienced by women with disability
- Theme 5 – Assistance
- Theme 6-Community attitude about intimacy and marriage, pregnancy of disabled people,
- Theme 7 -Are there laws that protect the rights of People with disability
- Theme 8-Possible solutions proposed by participants

5.2. Availability

5.2.1. Staff sufficiency and medicine availability

Most participants said that staff unavailability during ANC visits was a vital issue they encountered. A widespread problem, particularly in hospitals, is that most senior employees and specialists need help to locate during working hours.

"After all of the difficulties and challenges that I had in getting to the health care facility when the service providers are unavailable, or my appointment is canceled, it is disheartening and frustrating" (interview (5) with visually impaired woman)

Theme 1. Challenges to accessing health care facility

The majority of participants, particularly visually and physically impaired women, reported that their main problem in accessing maternal health care services is poor road conditions and that the corners of the roads are used as parking lots, making it difficult to cross the road safely and accessthe health care facility.

"*The roads are not built, and the asphalt is not accessible to individuals with disabilities. Most ofthe time when you cross the road, since there are misplaced cars which are parked, we frequentlyslip and collide, and there are also open maintenance holes, so getting to a health care center is the most difficult". (Interview (3) with a visually impaired woman)*

''Most of the roads in our living area are not suitable for persons who use wheelchairs, as they are uneven and difficult to paddle my wheelchair'' (interview (1) with physically impaired woman)

One woman with hearing impairment noted that

''Walking around the streets is dangerous for a deaf person like me since I can't hear cars passingby." (Interview (1) with deaf woman)

"Accessibility issues, infrastructure issues, staff unavailability, economic issues, a lack of knowledge from both the health service provider and the client, and a lack of information and knowledge about the services provided because some health providers do not educate them aboutthe available health care services are just a few of the challenges that WWD face."(Interview with focal personnel from the Ministry of Health)

"During my first ANC visit, I recall there was a long queue to obtain the ANC service, and I got there early in the morning and waited till the afternoon for my turn, but finally, I was told the specialist wasn't coming today, so the Nurse instructed me to come another day.'' (Interview (1) with physically impaired woman)

"Most of the time, when I had an ultrasound scan, I was told that the doctor had canceled my appointment." (Interview (4) with visually impaired woman)

5.3. Communication problems as experienced by WWD

Because there are no trained sign language interpreters, most women with speech and hearing impairments have difficulty communicating with healthcare providers. This is especially true if they go alone, as a communication barrier makes it difficult to understand what the health provider says.

"During my ANC visit, the doctor instructed me to purchase and take a medication, so I went to the pharmacy and he handed me the medication, but we couldn't agree on how many times I should take the medication daily, so he finally showed me with different funny gestures, indicating morning, afternoon, and night" (interview with a deaf woman (13)

"We are unable to discuss our health concerns and find a solution, and another problem is that our medical records are subject to inspection by third parties since we exposed our medical datato someone who could speak in sign language by coincidence. For example, suppose I don't want the person accompanying me or a family member to know about my health condition. In that case, I won't be ableto keep it a secret because there is no sign language interpreter. Therefore, I'll have to notify the person accompanying me. This is a violation of my privacy''. (Interview 14 with deaf woman)

"During my ANC visits, no one seems to comprehend what I'm saying. It's better to go with my husband because he understands me and tells the nurses what I'm saying. However, if I go alone, they won't understand me since no sign language interpreter is appointed, so I won't be able to discuss my health condition." (Interview 16 with deaf woman)

According to the interviews conducted with health professionals, the head of one health institution,and the hearing impairment and deaf association, communication barriers are a significant problem thatpeople who are deaf or hard of hearing and women with speech problems face when seeking maternal health care services because few to no health providers are trained in sign language.

"For example, in our health center, we serve hundreds of people every day, yet there is not a singleemployee who is trained in sign language" (head of a health institution)

"Three nurses were trained in sign language but unfortunately transferred to other hospitals. Thus, there is no sign language interpreter at present." But we now have a strategy to provide sign language training to our midwives." (Interview with senior Gynecologist Gynecologist)

"Many healthcare workers want to learn sign language, but only a few schools canteach it. We provide training to 1 or 2 health practitioners from each health center; however, owingto rotation and the departure of certain workers, this creates an opportunity. We even provided training to health workers who operate in remote locations.''(Interview with focal personnel fromthe Ministry of Health)

Theme 2 Healthcare provider's attitude towards WWD

5.4. Health provider's attitude regarding intimacy, the relationship of WWD

Most respondents claimed that healthcare professionals' attitudes toward them are demeaning; healthcare providers believe that people with disabilities are incapable of initiating romantic relationships or engaging in sexual acts, let alone getting married and managing their households. They might become judgmental when they take their children to clinics for checkups.

"When I went into delivery, the specialized doctor wanted to talk to my husband about my situation,so he invited him to come inside. When he did, the doctor noticed that my husband was also blind,and with a surprised expression on his face, he questioned my husband, "How did you guys make love?" My husband responded that a lamp is not essential to making love, and he even asked the doctor, "Do you use a lamp, Doctor, when you make love?" So, such questions aren't expected from a well-educated doctor (interview (8) with visually impaired woman)

5.5. Health provider's attitude regarding pregnancy, motherhood of WWD

Although some participants said they were treated with respect and even received encouragement and support from healthcare providers, over half of the participants said they hadencountered unfavorable attitudes from healthcare providers.

One physically impaired and one woman with visual impairment reported that the health providerswere supportive and caring.

"I was shocked when I found out I was pregnant with my first child because the pregnancy had notbeen planned, but the health professional supported me and advised and calmed me down, and she built my confidence and morale to continue the pregnancy." "Because I was economically insufficient, people helped me by bringing me clothes, and some even gave me money," she said (interview (11) with a physically impaired woman).

"The attitude of the health providers toward me was genuinely positive. They offered me priority to obtain the treatment without having to wait in line, especially during my ANC follow-ups" (interview with visually impaired woman 4)

Some participants indicated that health providers questioned their eligibility for motherhood, believing that people with disabilities are incapable of becoming pregnant and having a child, as well as their capacity to care for the newborn.

"They inquire as to how a disabled woman breastfeeds her newborn and cares for him; they eveninquire as to how we hold and nurture our children, which is not an anticipated question from a doctor." (Interview (5) with visually impaired woman)

Health practitioners feel that impairment is genetic and that it might be passed down to the fetus, according to one visually impaired and one physically disabled woman.

"It was tragic news when I learned that my newborn kid was blind as well, and the person whodelivered me asked me what was going on in my family that this type of thing happened as if it wasa curse, and he thought blindness ran in my family. I was so sad" (Interview 6 with visually impairedwoman)

"Health professionals are astonished when they see disabled, pregnant women since they usuallyassume that if a disabled, pregnant woman gets pregnant, she will give birth to a disabled kid."They believe we are destined to be incapacitated and that it will not affect them (interview 1 with physically impaired woman)

One physically impaired mother mentioned that during their ANC follow-ups, health providers become surprised when they see disabled mothers getting pregnant.

"When I initially went to the health facility to start my ANC follow-up, the health professionals stared at me with amusement and as if I was the first physically disabled person who became pregnant." (Interview with physically impaired 13)

"Some health workers mock people with disabilities when they see them getting pregnant; we haveobserved this, but not all health professionals are like this. All disabled individuals have the rightto marry and have the same needs as non-disabled people. The Minister of Women and Children's Affairs has attempted to raise awareness through the mass media, television, and radio, but the problem persists because it cannot reach the entire community; as you know, health professionals are also part of the community, if we address the community, we can address the health professionals as well."(Interview with focal personnel from Addis Ababa Health Bureau)

Based on the experiences of WWD, we may deduce that certain health providers marginalize disabled women by employing negative attitudes and presuming that WWD is unable to get pregnant, care for their children, and support their families.

5.6. Health provider's discrimination and insensitive care, as experienced by WWD

The majority of interviewees expressed their and their friends' experiences at the health care service, stating that they encountered negative attitudes, stereotypes, misconceptions, and outrightdiscrimination by health providers against people with disabilities. As a result of this disparity, thequality of care they received was low, putting their health and the life of their fetus in jeopardy.

"I was assured that they will operate me by elective c/s for the correct purpose." And I consented, but they performed the operation many days after my scheduled date; they continually postponedme; and if I hadn't had someone to speak on my behalf, I doubt I would have been operated at all.'' (Interview 1 with physically impaired woman)

"When I went to have my first kid, I experienced many difficulties. During my Labor, I was nude,and they didn't provide me a bed sheet or a blanket to wear. When my pushing down pain increased, they took me to the delivery room and asked me to lie on the delivery coach; they didn'tgive me any clothes, the room was freezing, and after I gave birth, I was soaked with blood, when I asked them to hand me my cloth, the health providers, scolded at me and shouted at me, she wasnot polite. She was so aggressive that she told me to remove my jacket and put it underneath my soaked clothes. They were impolite." (Interview 2 with physically impaired woman)

One visually impaired woman mentioned that she lost a friend due to a lack of attention and care provided to PWD; according to her, if more attention had been paid to PWD, her friend would stillbe alive.

"Two years ago, a blind friend of mine became pregnant and went into labor, but shortly after shegave birth, she began to bleed terribly, and after a time, they informed us she was dead." We were in a state of shock, even though her death was unjustifiable. I actually (blame) point my finger at health professionals, wondering what could have gone wrong in that health institution that put herlife in danger and caused her to lose her life. You know she had ANC follow-ups, and I believe if she had a problem, it would have been picked up during ANC visits. She is giving birth in a higher health institution, which is a referral hospital; there are specialists who could treat her. (Interview 4 with a visually impaired woman)

Some respondents stated that their personal and their friends' experiences throughout ANC, intrapartum time, virtually all of them agreed that the health professionals' insensitive approach, lack of care, and maltreatment was a big problem during their pregnancy, delivery, and postpartumperiod.

"I noticed they lack patience; there were a few who insulted and scolded us during labor, and, in my account, they didn't support me psychologically; I was a preeclampsia patient, I was under a lot ofstress, and my newborn was fighting for her life because she was preterm, but no one said everything would be fine and supported me. Instead, they scolded me." Maybe they were acting this way because they were busy, and maybe their job was demanding, but I can't excuse their conduct and behaviors toward me in my most vulnerable moment. It's immoral for them to take out their frustrations on me; this is abuse.'' (Interview with eight visually impaired women)

Two participants said that when they went to a healthcare institution to seek a service for family planning or VCT (volunteer counseling and testing of HIV/AIDS), the health practitioners were judgmental and violated their autonomy in making decisions.

"Some health providers compel us to use long-term family planning so that we don't become pregnant; they are so judgmental and make decisions for us without consulting us."(Interview with (11) physically impaired woman) "When we asked health professionals to show us where HIV testing and counseling services are provided, they responded by asking if we wanted it for ourselves or other people."(Interview (8) With visual impaired)

On the contrary, according to the interviews with the health professionals and the head of one of the health care facilities, virtually all health providers are compassionate and helpful. They do not discriminate against people with disabilities but offer precedence wherever feasible.

"Health professionals' attitude toward people with disabilities is positive; we are more helpful, and we do not discriminate in any manner; in fact, we give priority to people with disabilities over people with disabilities when they come to health care facilities."(Interview with a midwife 2)

"Being a health professional helps me understand PWD better," says the midwife. In college, we learned in the Nursing art course how to be caring, compassionate, and empathic towards people in general, which helped us have a positive attitude. (Head of a health-care facility)

Theme 3. Attitudes of Auxiliary Service Providers

5.7. Healthcare facility security Guards and cleaners

Some of the interviewees stated, based on their own and their friends' experiences, that negative attitudes come not only from health providers but also from non-clinical staff who work inthe health care facility; the problem begins when they enter the health care facility, starting withthe security guards and janitors.

"When I walk into a room where they are cleaning or washing the floor, they refuse to let me passand instead ask me to stay motionless in my position; I have no clue where I am because I am blind." (Interview 5 with visual impaired woman)

According to an interview with one of the health facility administrators, the problem is that the cleaners and security guards have never gotten any instruction on how to handle persons with disabilities.

"They've never had any training on how to address PWD with respect." (Head of a health care facility)

According to one visually impaired lady and one gynecologist, security guards and cleaners are sympathetic and have a favorable attitude toward people with disabilities.

"The security guards and cleaners are wonderful; in fact, one of the cleaners was calming me during the delivery and assured me that the anguish will pass." (Interview 9 with visually impaired woman)

"They have a cheerful attitude, they assist those with disabilities by pointing them in the right path,and they support them as they travel up the stairs." (Interview with senior Gynecologist Gynecologist)

Theme 4. Healthcare infrastructure as experienced by PWD

The hostile character of healthcare infrastructure, according to all respondents, is one of the biggest problems that women with physical impairments and visual impairments encounter in receiving expert treatment. The most notable barriers for WWPD in accessing health facilities were a lack of wheelchair ramps, high stairs, a lack of personnel to assist WWPD in climbing stairs, a lack ofassistive devices, a lack of elevators in the health centers and the elevators in the hospital frequently malfunction, narrow doorways and corridors, and open ditches in the compound arethe significant problems encountered by PWD.

"It is not conducive; there is a health center in my village; when you are in the compound and want to go to the toilet, you need assistance that can lead you because on the walkway there are open ditches, one might fall, especially blind people, I can only say it is conducive if one disabled person can move around in the compound without assistance more than50% of the time by himself or herself.'' (Interview 8 with visually impaired woman)

"Most buildings that provide services were created a long time ago, and they did not consider the needs of disabled people; - even newly constructed health centers and hospitals that were established seven years ago were designed without considering our needs. The delivery suites are mostly found on the second floor, with a rump until the first floor but no rumpbeyond that, making it difficult for wheelchair users and crunch users to climb the stairs. Most Government officials promised to do this and that, but no tangible work has been done." (Interview 1 with physically impaired woman)

"Healthcare institutions are truly unsuitable for persons with disabilities or impairments. The routes at hospitals are not accessible to blind persons like me; there are many steps, tiny hallways, zigzags and narrow walkways. Furthermore, the property has large open maintenance holes and ditches that might put us in danger of various disabilities, especially if we are alone. Thehazards are beyond comprehension. For example, if I fell, I might endanger both my fetus and myself, or I could develop another impairment." (Interview 5 with visually impaired woman).

Interviews with health professionals, the head of the healthcare facility, and the head of the blind associationall affirmed that the facilities are uncomfortable and conducive to PWD. They noted that the healthcare facilities were built without considering the needs of PWD, and as a result, PWD faces several difficulties when seeking maternal healthcare services.

"Difficulties for pregnant women with disabilities vary according to the sort of disability they have; for physically disabled people and those who use wheelchairs, there is no rump on which they can paddle their wheelchair. The healthcare facilities are inaccessible, and some requireaid to guide them inside; there are no elevators, and there are no separate toilets for wheelchair users or physically disabled persons. During ANC visits and ultrasound examinations, theexamination beds are fixed and inaccessible, making it difficult to accommodate physically disabled patients. The floor is ceramic and extremely slippery, putting people in danger." (Interview with branch head of blind association)

"During their ANC visits, especially for blind individuals, it's tough for them to walk around in thehealth care facility and navigate by themselves; they require aid; thus, it's a struggle; there is no designated employee that could show them and take them to the service they want to attend." (Interview with a Midwife)

"There is no separate gait that wheelchair users could get inside; in addition to this form postal period women, it is difficult because the post-natal room is found on the second floor, it is difficult for newly delivered women to ambulate and to go upstairs because their body is weak from the delivery, the elevators don't work, there are no ramps for wheelchair users all these problems pills up and create a lot of challenges, and sometimes, due to these problems, and the other bottleneck.

for them, in my opinion, the place where ANC visits are provided is on the first floor, but it is inconvenient; - the rooms are tiny, there is no rump for wheelchair users, and the building appears to have been designed primarily for non-disabled persons, not handicapped people." Thebuildings are not comfortable for us, even as disabled people; -inside the building, the rooms are narrow, the corridors are narrow and congested, and it barely accommodates two people to pass inside the corridors at the same time; this makes it difficult for wheelchair users to paddle and for blindpeople to walk in this congested area, to make matters worse, there is a waiting area with a bench where pregnant women sit until their names are called.'' (Interview with a senior gynecologist)

''To be honest, I can't say that all of the infrastructure problems are due to one cause; there couldbe many, but in my opinion, it's because we're underdeveloped, the country is poor, and most hospitals and health centers are built by the government budget, and the county is poor; as a result,most of the health centers were built a long time ago and didn't consider the needs of PWD; on theother hand, newly constructed buildings have made a few changes, but only partially, and there are no serious obligations that force building to incorporate the needs of PWD during construction, and there appears to be a reluctance and lack of follow-ups, only recommendationsthat rely primarily on the will of the construction company, so building and construction laws should be exercised and implemented in every sector, and those companies that fail to do so shouldbe punished according to

construction law regulations." interview with focal personnel from Ministry of health)

"PWDs now have easier access to buildings thanks to the passage of the Building Proclamation. Various associations of PWDs get financial and technical assistance. However, the number of beneficiaries is small compared to the overall number."(Focal personnel forlabor and social affairs)

6.1. Examination beds, obstetric laboring tables inside the HCFs

Another physical barrier that prohibited WWD from receiving adequate maternal health care was inaccessible and hostile equipment. Health facilities lacked adjustable examination and delivery beds that could be lowered for WWPD. As a result, climbing to a high bed was difficult for WWPD, and they needed assistance from their companion.

"The examination beds were not pleasant during my ANC visits and ultrasound examinations; theywere fixed and not accessible; it's difficult to alter the examination beds; this makes it significantlymore problematic, especially for physically disabled persons." (Interview with physically impairedwoman)

"The examination beds were fixed and inaccessible during ANC visits and ultrasound exams. Therefore, every health care institution should conduct a handicap-accessible audit to determine which areas require modification, adjustment, and implementation." (Branch head of Blind Association)

"The delivery tables were neither adjustable nor flexible." There are no step-down beds in the labor wards, making it difficult to adjust the beds to our client's needs." (Interview with a midwife)

"The examination beds are fixed, and the bed is raised high off the floor, so when a pregnant woman in a wheelchair comes in, and we want to examine her on the bed, it's difficult, so we need help carrying her and putting her on the bed as you know, this is difficult for both the clients and us and the laboring couches are not comfortable, they are fixed and not flexible, and it is difficultto maneuver the couches according to each disability need.'' (Interview with Gynecologist)

"Most health services, in addition to purchasing new beds, often modify existing beds, sometimesusing spare components from previously disused beds to make them useful. We are genuinely acquiring adaptable beds, but they are so expensive that we are unable to satisfy the demands of all healthcare institutions since the authorized budget is not equal to the price."(Interview with head of Addis Ababa, health bureau)

"We are purchasing flexible beds, but they are so expensive because the allocated budgetis not comparable with the price, so we cannot meet the demand of all health care facilities.We are purchasing flexible beds, but they are so expensive because the allocated budgetis not comparable with the price, so we cannot meet the demand of all healthcare facilities."(Interview with focal personnel from the Ministry of Health)

6.2. Pharmacies, laboratories

Some interviewees mentioned that pharmacies and laboratories are convenient because they are located on the first floor, but they are not aligned in close proximity, so in order to receive service, one must travel a long distance, which is costly, especially for the disabled. The service windowis high above the floor, making it difficult for wheelchair users to reach the service window and hand their laboratory requirements.

"Because the pharmacy and the laboratory are in separate locations, it is difficult for physically impaired people to walk around; - it would be better if they were aligned together nearby because I can't see or read, and asking for directions is also bothersome." (Interview 4 withvisually impaired woman)

"The pharmacies were built solely with able-bodied people in mind; the service windows are difficult to reach from a wheelchair, so one should ask others to handle the pharmacists' prescriptions." (Interview 10 with physically impaired woman)

One visually impaired woman mentioned the unavailability of braille-printed pharmaceutical packets so that she could read what was written on the leaflet; as a result, she had to seek other people for aid, which violated her privacy if she wanted to keep the medication; she was taking a secret from others.

"About pharmacies, in private pharmacies, there are written instructions in braille on themedications package, making it easy for a blind person like me to read it and take the medication appropriately, but in most government health institutions, there is no such thing, so I have to relyon others to read it for me." (Interview 6 with visually impaired woman)

6.3. Toilets inside the healthcare facilities

The majority of the interviews stated that there are no distinct toiles for people with disabilities, particularly wheelchair users.

"There is no separate toilet for PWD, especially wheelchair users; it is a community toilet, whichis filthy and has damaged toilet seats; there is no separate toilet for PWD, especially for wheelchairusers, its communal toilet, they are not clean, some toilet seats are even broken.'' (Interview withGynecologist)

"The cleaners don't mop the floor, which makes the laboring ward smell bad. You can smellbad air coming from the toilet when you are in the labor ward, and it even aggravated my vomiting and made it worse.'' (Interview 8 with visually impaired woman)

"It is an issue of not paying enough attention; if we are unable to prepare separate restrooms, wecan at least combine toilets to make them accessible to both able-bodied and disabled persons." (Interview with focal personnel from Ministry of Health)

6.4. Direction sign board and door signs inside the health care service

Half of the interviewees said they needed help finding where the services were provided since no one was assigned to guide them, there was no information desk receptionist, and the direction sign boards were difficult to comprehend. Furthermore, several healthcare facilities needed direction sign boards, making traveling and designating service areas difficult. At the same time, some said that in the service area, the doors had no sign indicating what service was providedin that room, making it more difficult for the disabled mothers and their caregivers to get them tothe appropriate care provider.

"*What was difficult for me during my ANC visit was finding the ultrasound room because they don't have a designated room where ultrasound scans are done, so one day, they used this room and changed it another time. Furthermore, the rooms don't have a written sign on their door indicating what services are provided in the room'' (Interview 4 with visually impaired woman)*

"In most established health institutes, there are no information desks. And there are no designatedprofessionals whose duty it is to lead or guide us in the direction we want to go in the healthcaresystem. When we ask others to show us where to go, they usually tell us to walk to the right or left,but since we can't see, this isn't very helpful; -so I have to navigate on my own, which is time-consuming and exhausting, especially for pregnant ladies with swollen feet." (Interview 3 with visually impaired woman)

"There was no one to show us the way, and it was difficult to maneuver within the facility." Becausewe can't see, figuring out how to acquire service has been difficult, so I've been asking others to show me the service site.'' (Interview 8 with visually impaired woman)

"The health facilities lack an information desk that may assist us in locating the locations and rooms where services are provided." This is a massive issue because there are no direction board signs. Not only for us, but also for our caregivers, it is tough to travel throughout the healthfacilities." (Interview 5 with visually impaired woman)

"Our health care institution has a less structured information desk area." There are also guidance boards. It is expected to find sign boards that are bent down or lying on the ground, someof which are difficult to comprehend and do not make it apparent what they are for in the first place, and some of which turn their faces away from other directions (directing to a service that is not provided). Furthermore, because these boards were erected long ago, the printed words have faded and are difficult to see." (Interview with Gynecologist)

"This is a matter of proper and open administration. There is a charter in Ethiopian health institutions that states that all of the lists of activities given, the available open hours, and the prices of services should be readable. Still, as you can see, most health facilities do not follow this, and those that do follow it because they display it in papers, the rain will wash it away, and they will vanish after a while. Those in charge of the WOREDA'S and the sub-cities should change this by performing follow-up and monitoring." (*Interview with focal personnel from the Ministry of Health)*

6.5. Theme 5. Assistance

Most interviewees mentioned that they had a significant problem during labor and the postpartum period because most healthcare facility attendants, including husbands, are not allowed to visit laboring mothers, making childbirth a triple burden for PWD, one being a disabled person, the other being in LaborLabor, and the third being a lack of assistance. Most of the women stated that labor is a peculiar period in women's reproductive life that they need most of the support, care and love, but because of lack of assistance, most WWD experience a hard time.

"When I wanted to drink or eat, there were no nursing assistants available to assist me, maybe because the midwives were preoccupied with the constant flow of laboring moms, and no one was paying attention to my needs." They should have permitted my attendants to enter the labor unit ifsuch was the case. I required assistance since I was constantly vomiting, and no one could bring me a bedpan or a liquid waste collector if they had only let my family members inside. The room, I would have felt much better. I highly encourage and advise them to allow at least oneattendant to remain with a laboring disabled mother in the future.''(Interview 8 with visually impaired woman)

"I encountered a huge stumbling block during delivery. I had a lot of difficulties because no one was allowed to come inside to the labor ward during labor, so I had to figure out how to do thingson my own'' (Interview 3 with visually impaired woman)

"After the operation, I lay on my bed, but there was no one assigned to position me and assist mein ambulating. I'm sure I would have faced a lot of difficulties if it hadn't been for my non-disabledhusband. It is a universal reality that every pregnant woman, at the absolute least, requires love and support, as well as extra attention and care. Imagine the stress of being pregnant and disabledat the same time. She has to take on a lot of tasks, and the strain is too great. As a result, they require much more care and particular concern than non-disabled pregnant women" (interview 10 with physically impaired)

"It is, in my opinion, a serious issue. We don't allow anybody to visit them when they're in Labor. Because the rooms are tight and there are a lot of pregnant ladies giving birth at the same time, we don't allow attendants to come inside, which I suppose makes it a little difficult.'' (Interview with a midwife)

"Because attendants aren't permitted to enter the laboring room, and most of the time our midwivesare busy, it's difficult to satisfy their needs, but we try to comfort them as much as we can as if wewere a family member, but after the procedure, we enable the attendant to stay with the postoperative mother and ambulate her." However, if they do not have an attendant, the maternity nurses or our nursing students will assist them in walking." (Interview with a senior Gynecologist)

"This is the infrastructural issue. In labor wards, there are few delivery tables and no designateddelivery rooms for disabled and non-disabled persons. Every lady requires her own space. Not to intrude on the other laboring mother's privacy. If it weren't for the following reason, most midwiveswouldn't let attendants in. It would have been preferable if one of the attendants, or the husband, had been present with the laboring mother."(Interview with focal personnel from the Ministry of Health)

Theme 6. Community attitude about intimacy, marriage and motherhood of disabled people

Most of the ladies had a mixed impression; some believe that the community's attitude toward people with disabilities is changing, while others think that there is still a gap in the community's attitude toward people with disabilities. They imply that people with disabilities face societal uncertainties and discrimination about their sexuality and parenting ability. WWD were frequentlylabeled as asexual, indicating that they lacked sexual desire and were unable to reproduce. WWD were regarded to be unfit for motherhood and incapable of providing a suitable home for their children. WWD were considered to be a hardship for both moms and children while having children.

"When I carry my four-month-old on my back, people are astonished; I recall one person approaching me and asking me whose child I was carrying; the community does not change" (interview 1 with physically impaired woman)

"They say while she is physically impaired, how could she bring a life into the world, to make himsuffer, she isn't even

independent and adequate to sustain herself, let alone to care for another,"(interview with 10 with physically impaired woman)
"Individuals' attitudes toward people with disabilities have been severe, but we are witnessing some improvements lately, such as how they used to think of us as beggars, but now they approach us and inquire if we are students or employees.'' (Interview 5 with visually impaired woman)
Three visually impaired women noted that the community's attitude is more judgmental, particularly toward blind women; when they see blind women, they advise them to give birth so that their child will lead and support them in maneuvering around the house and outside. They also received advice on whom to marry, specifically to avoid marrying a blind man, because the community believes that they will have a problem because both couples require assistance.
"Once, while walking through my village, a woman approached me and questioned why I wasn't married and recommended that I get married and have children, saying that if I do, my children will lead me," she said. But, when you think about it, it has a bad connotation since she was judgmental because, without questioning if I was married or not, or if I had children or not, she inferred that I was neither married nor had children. Another thing is that I give birth, not so much.
My child can lead me so that I can see my children, love and care for them, and educate themjust like any other capable person. And nurture them to grow up to be productive, successful citizens who serve their nation. I tried to explain to them with anxiety at times, but I also left them without saying anything". (Interview 8 with visually impaired woman)
"However, there is still an issue, particularly when we begin our love and connection; -when theylearn that we are married, they wonder how on earth that is possible, and how we manage and keep our marriage and they stated, "If one disabled person marries a non-disabled person, one can lead the other, but in the case of you guys, who will lead who?" They raised their eyebrows, especially when they watched two blind individuals get married.'' (Interview 3 with visually impaired woman)

Due to her condition, one blind woman stated she had difficulty joining a social membership in her town. They feared that her impairment would prevent her from performing and being an activeparticipant in her society.
"It is difficult to join EDER and EKUB in our neighborhood and to participate in various community events since the situation is so difficult." They believe that my disability will prevent me from participating in community associations" (Interview 8 with visually impaired woman)

One physically disabled lady said that her lover left her because he didn't want to be seen with a physically disabled woman.
"My boyfriend, who is the father of my kid, left me because he doesn't want other people in our community to know that I am his girlfriend because I have a physical disability, and he even disputed that he is the father of my child and doesn't help us at all." (Interview 11 with physicallydisabled woman)

Two interviewees mentioned that the community believes impairment is inherited and runs infamilies.
"They believe that if a blind woman becomes pregnant, she will have a blind kid, and if a deaf woman gets pregnant, she will have a deaf baby, and the same is true for other impairments." People assume that disabilities are passed down from generation to generation, which is especially.
Accurate in rural areas when compared to metropolitan attitudes." (Interview 4 with visually impaired woman)
"Some individuals believe that disability is a contagious sickness that can be handed down to children and that it is genetic. Therefore, they are frightened to form relationships with people whohave disabilities."(Interview 3 with visually impaired woman)

Theme 7. Are there laws that protect the rights of PWD?
Are there any laws that safeguard the rights of people with disabilities? When asked whether thereare laws in our nation that guarantee the rights of people with disabilities, the respondents indicated that they have the right to obtain and utilize healthcare services whenever they need them. Still, they don't know where to go if their rights are infringed.
"As a human being, I have the right to use healthcare services whenever I choose, without discrimination or prejudice" (interview 15 with deaf woman)

According to an interview with a gynecologist and the head of one of the health institutions, theydon't know if Ethiopia's health minister developed a separate document or manual to defend the rights of people with disabilities.
"I'm not sure if there is a written legislation that protects the rights of people with disabilities." (Interview with head of health institution)
"if they have any grievance, they take their grievances to the focal area that any person with a grievance is heard, but our experience most of the time is, they write up their comment or complaint and *put it on the comment box, sometimes we read it but, most of the time we don't readthe papers, so it's hard to know whether they were satisfied with our services, or not (interview with senior Gynecologist)*

We may deduce from interviews with the heads of the visual impairment and hearing impairmentand deaf associations that the government has accepted and ratified the rights of persons with disabilities, but that implementation is the issue.
"The UN PWD rights convention, as we call it, is an international legislation that protects the rights of PWD. Ethiopia has ratified the convention, endorsed it in its constitution, and put it into Effect. However, I feel there is a gap on the implementation side; when a disabled person's rightsare violated, they can go to court, but it is not as simple as it appears; there are many proceduralinaccuracies." (Interview with branch head of blind association)
"There are laws that Ethiopia is using to protect the rights of people with disabilities. However, there is a problem with implementation, mainly due to the problem of the people who are assigned to carryout the endorsed convention. They don't have a formal meeting, and Ethiopia doesn't have a disability act, unlike developed countries, which opens a huge gap to protect the rights ofpeople with disabilities."(Interview with branch Head of Physical Disabilities)
"A proclamation for the Right to Employment of Persons with Disabilities was issued to promote the rights, equal opportunities, and participation of PWDs. In addition, a National Physical Rehabilitation Strategy has been created. A more precise directive (36/98) has been published andis in effect

for the tax-free import of wheelchairs and crutches for PWDs." (Interview with Focal personnel from Labor and Social Affairs)

7. Possible solutions

7.1. Regarding infrastructure

Most of the participants and also the focal personnel, who are branch heads of different disabilityassociations and heads of healthcare facilities, affirmed that the healthcare infrastructure needs to be modified and that it should be made disability-friendly in all areas of the healthcare delivery system.

"If the service offered to us could fit the demands of each of us, based on the type of disability thatwe have, they should sort out the needs of each handicapped person, for blind pregnant ladies, what she needs?" What does a physically challenged woman require? And responding to their needs in a timely manner." (Interview 3 with visually impaired woman)

"When the buildings are constructed, ramps for wheelchair users must be installed, and narrow roadways should be enlarged, staircases should be eliminated and replaced with elevators, and existing buildings should be modified properly." "(Interview 6 with visually impaired woman) "Every healthcare facility should conduct a disability-accessible audit to determine which areas require modification or adjustment, and then implement the necessary changes." (Interview with branch head of Blind Association)

"In every health institution, there needs to be a special field unit that works with people with disabilities only, that can provide them with assistance for their specific needs, and that can accept any grievances that come from people with disabilities."(Interview with head of the deaf association)

"The existing buildings need to be modified, and the new structures that are now being built should consider the needs of the disabled. Finally, all other sectors in the country, such as water, construction, and transportation, and we assess buildings for wheelchair accessibility incollaboration with other relevant sectors. Because the rules are flexible in their implementation, the challenge is in implementing and enforcing them. Thus, we must collaborate and correct our weaknesses." (Interview with focal personnel from the Ministry of Health)

"*The government has expanded prosthetic and orthotic services, including physical rehabilitation center infrastructure, machinery, and interventions in this area, over the last ten years. Interventions in this area have primarily focused on creating an enabling environment for peoplewith disabilities to access physical rehabilitation services, and Fee exemptions, approved by the Woredas administration, are provided to many of the neediest people in the health sector, allowingthem access Accessibility.*

to health services. (Interview with focal personnel from Labor and Social Affairs)

7.2. Solutions proposed by participants regarding training to create a better awareness

Most participants proposed that health professionals get training on approaching WWD best and addressing their needs, and they should be taught sign language. They also suggested that the Ethiopian curriculum incorporate a course on disability to create awareness of howto prevent it and live with it when it occurs.

"They should also teach sign language to health professionals, guards, cleaners, and any other service provider because deaf individuals find it difficult to speak with health experts owing to communication difficulties.'' (Interview 4 with visually impaired woman)

"Ethiopian education curriculum should be revised, and our children should learn it in schools, just like any other subject, about how to avoid becoming disabled, especially for preventable types of disability, and how to help, how to be compassionate towards WWD; - if we cultivate them from an early age, the attitude issue will not exist because we are all vulnerable to being disabled. Nobody is marked as physically disabled when they are born. "(Interview 11 with Physical Impaired woman)

"Right now, we're delivering a program called CRS (compassionate, caring, respectful service for all) to help people become compassionate, caring, and courteous toeverybody who comes to a health facility, whether they're non-disabled or disabled. Another thing is that we assess our employee's performance and discipline. We encourage those who have conduct concerns to change their behavior or actions. I am confident that this CRS training will transform HP's mentality quickly and that they will become more caring and understanding of everybody who comes to obtain care". (Interview with the head of a healthcare facility)

"As an organization for the deaf, we provide training, such as sign language training, to peoplewith hearing impairments and the deaf so that when they go out in public, they can at least interactwith others who have studied sign language. In terms of providing sign language training to healthprofessionals, we have been collaborating with the Ministry of Health and the Addis Ababa HealthBureau to train staff. In the last 5 to 10 years, we've taught many people who now work in health centers and hospitals. I understand that it may not be sufficient, but we will continue to train additional health professionals in the future." (Head of deaf association)

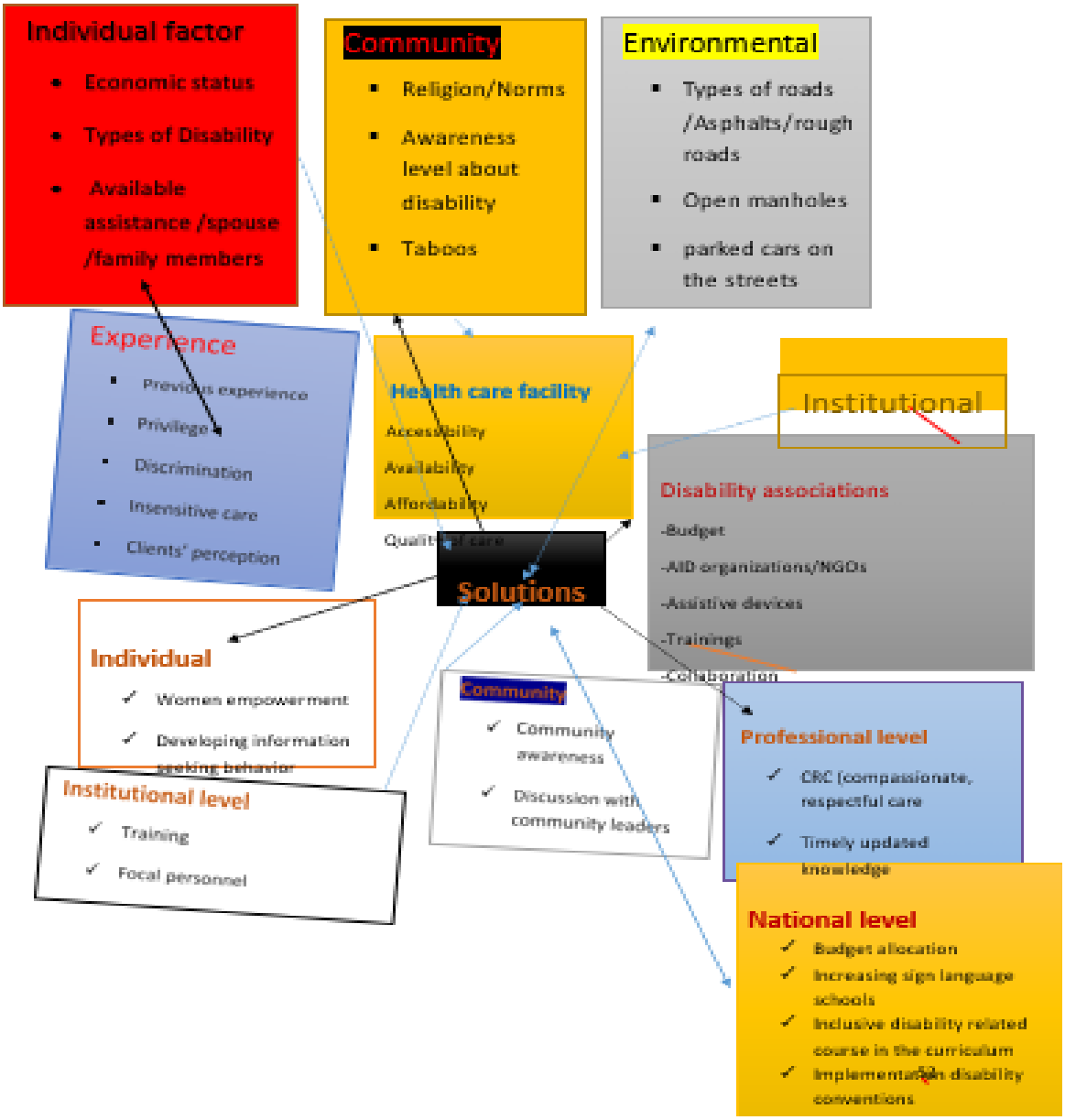

Figure 1; Conceptual frame work drawn from this research.

8. Discussion

The majority of the health care infrastructures were unfriendly for PWD, with no rumps in two ofthe health institutions and rumps that only go to the first floor in the remaining health institutions,making it impossible for wheelchair users to receive immunization and family planning services on their own. Only four of the seven healthcare institutions have elevators, of which three were functional, from the observation during site observation. Also, there were no separate toilets for physically disabled people, and most obstetric delivery tables, first-stage laborward beds, and examination beds in ultrasound rooms and other reproductive health-related services areas lacked adjustable examination beds, making it difficult for physically disabled women to use them. Furthermore, there were only direction boards or information desks in the 3 of the seven healthcare facilities, only readable in two of the healthcare facilities, making it difficult for people with disabilities to navigate specific service locations. Also, based on the site observation, there were no designated separate gates for wheelchair users and other disability types in nearly all of the healthcare facilities that were observed, and the ambulances lacked a rump inside them that could help to quickly transfer physically impaired people and wheelchair users in to or out of the ambulances.

One hundred sixty-six countries have ratified the Convention on the Rights of Persons with Disabilities. Ethiopia is one of them. It has a Building Proclamation, No. 624/2009, which requires accessibilityin the design and construction of any building to ensure suitability for physically impaired people,but the reality is far from ideal; most participants claim that most healthcare facilities are unfriendly to people with disabilities, particularly women with disabilities. The majority of the participants felt that healthcare facilities were solely designed to cater to the needs of the non-disabled, and some even stated that they regard themselves as outcasts since the government pays them less attention even though they are members of the community. Most healthcare facilities have no ramps or elevators, adjustable beds or obstetric delivery tables, tiny hallways and zigzag walks, and open ditches. While the Ethiopian Ministry of Health is responsible for providing general health services to people with disabilities as well asthe rest of the population, there appears to

be no explicit focus on disability in health policy. Therefore, the care system and services need to be improved. Previous studies that were done in this area actually indicate similar findings, a study that was done in Hawassa, Ethiopia [34].

Most participants believed that even though they are part of the community, they question whetherthere is a concerned body regarding their health; even interviews with key informants suggested that this segment of the people has not been put into consideration during health service provision but seems the reality is identical, the Ethiopia health policy regarding people with disability is the same as the none disabled people, the policy emphasizes only on the prevention aspect and the provision of primary health care services to all segments of the population. The community-based health extension program targets households, particularly women and children at the grassroots level,to prevent and control major fatal diseases. A Health Sector Development Program (HSDP) coordinates donor assistance in supporting the country's health infrastructure and human resources development. [35] The policy mainly emphasizes the prevention side, but this segmentof the people needs curative medicine and rehabilitation facilities as well.

Ethiopia's health policy has changed its Medical model, which looked at disability simply as a medical problem that needs to be solved or an illness that needs to be "cured." to a social model and human rights model, which views PWDs as being disabled not by their impairment but by society's reaction, or lack of response to them and the human rights model which emphasizes that, the rightsof PWDs as equal to all citizens and the basis for all action to support their equal access to services and opportunities. However, the findings from this study contradict wildly as most participants need equal access to services due to many obstacles, such as a lack of friendly infrastructure in the health facilities. Even though the country's perspective towards disability has changed, the service provision is still low. Some articles regarding this stated the same [36].

Also, some participants in this study, particularly those with visual impairment, stated that they had difficulty navigating and finding health care services while inside the health care facility compound due to a lack of direction sign boards, a lack of focal information desk receptionist, anda lack of assistive personnel. This finding is consistent with the findings that were done in Yekatit12 Hospital Medical College, Ethiopia [37], and this finding was consistent with the previous study conducted in Bahirdar, Ethiopia, in which 74%of the participants were dissatisfied due to the absence of signing direction [38].

The communication barrier was also one of the significant issues raised by deaf mothers in this study, whoclaimed that they had a difficult time communicating with healthcare providers while seeking maternal healthcare services, such as family planning during ANC follow-ups and the intrapartum.

Period. This is primarily due to the limited availability of written materials in sign language about maternal and child health and the unavailability of sign language interpreters. On the other hand, visually impaired mothers claimed that because prescriptions are not provided in accessible formats, such as Braille or large print, this creates a barrier for people with vision impairment. As a result, they claim that their confidentiality and privacy are jeopardized because they will seek assistance from others, exposing their medical records to scrutiny, even though there is a working standard for healthcare facilities that the Ethiopian Ministry of Health set that states that to receive, to the extent possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel[39]. More implementation needs to be done in each care health facility. His findings are consistent with previous studies in Nepal and Ghana [4, 40].

This study also reveals that lack of assistance, particularly during the intrapartum period, is a significant issue, as most women with disabilities claimed that during labor, the laboring mother's attendants, family members, and even their husband were not allowed to visit her; no one couldhand them necessary items, such as water, bed pans, and who could take them to the toilets; and most participants, particularly visually impaired mothers, had a difficult time. Because of their disability, they had to adjust to the laboring environment without the help of their family and figure it out on their own to take care of themselves during labor, and the physically impaired mother had a difficult time because no one supported and reassured them during labor; on the otherhand, deaf mothers reported communication barriers, and it was difficult to know howfar along in labor they were in addition. Also, through the triangulation methods, health providersagreed that they don't allow visitors inside the labor ward. This finding is consistently reported in many previous studies in Nepal [4].

The views of health professionals toward persons with disabilities were found to be varied in this study. Some participants said that healthcare professionals were compassionate, sensitive, and even prioritized them, whereas others claimed that they were met with unfavorable attitudes fromhealthcare providers; - It could be due to a lack of health-worker training on issues of disability, erroneous assumptions about the asexuality of women with disabilities and unfitness for motherhood, and many other healthcare providers' insensitivity, lack of care, insult, and ignorance, to name a few. This is constituent in a Systematic review that was done in Ethiopia, which indicated Women experience insult, shouting, intimidation, and threats without provocation and insensitiveness to the patient. [41] It could also be due to a lack of health-worker training on issues of disability, erroneous assumptions about the asexuality of women with disabilities, and unfitness for motherhood; many healthcare personnel have poor awareness of the rights of persons with disabilities, lack of proper training, and believe that disabled people are unintelligent, to name a few unfavorable views .some participants also mentioned that some health professionals are amazed and became surprised especially when they see PWD getting pregnant .this findings resonate with other studies that was done in this area, Nepal, Ethiopia[15][19].

Most of the participants claimed that even though society's attitude toward PWD is changing as PWD become more educated, lead a good life, get married, and build their own lives, there is stilla stereotype and negative attitude in the community. This study also reveals that there is little awareness about disability culture among a wide range of society, e.g., these cultural perspectivesare especially significant when it comes to moms with disabilities who are subjected to societal stigma and erroneous assumptions about their capacity to marry, manage their marriage, and raise their children. According to several interviewees, the community feels that the condition might be passed down to the kid; thus, they should avoid all forms of closeness and relationships. On the other side, according to some interviewees, the community regards them as incapable of many things, one of which is self-sufficiency, therefore they feel

they shouldn't bring a human being intothe world since them, too, are dependent and require care much alone to care for another human Bing. Some participants, on the other hand, stated that some individuals recommended they getpregnant so that the baby would lead them to maneuver within or outside the house. Some studiesin this area also noted similar findings [16].

This study also sought to determine what possible solutions most women with disabilities would propose to improve the service provided to people with disabilities. They all agreed that the Ethiopian government should establish a disability-friendly healthcare facility, such as building elevators and ramps, and, if possible, locating all maternal and child services on the first floor and allocating them nearby. They also suggested that all health personnel receive sign language training and instruction on how to be more caring, empathetic, and respectful of people with disabilities.

9. Conclusion

In general, the study found that women with disability face a lot of challenges in accessing maternal healthcare services. Most of the healthcare facilities don't take into consideration the needs of people with disability, healthcare facilities are not disability-friendly, and the constructions don't take into consideration the needs of each disability type during designing. Even though the country has building laws that enforce any building with two blocks or more isrequired to have an elevator inside them, nearly all of the health centers don't have an elevatorinside them, and in hospitals, most of the elevators are not functional which is a big challenge for WWD. The reason why the building legislation failed to meet the building regulation needs further researchand study.

This study also found that healthcare providers' attitude towards WWD was found to be negativeinsensitive care; discrimination is the major one. Even though most the health care facilities give training on CRC (to provide caring, respectful and Compassionate) health providers to all segments of society, the training and the courses do not contain disability-related information or concerns; this opened a gap in knowledge and skill on the health care provider on how to best address the needs of WWD. Also, the Ethiopian education curriculum does not include courses about preventing disability, treatment modalities, and rehabilitation.

This study also reveals that there are no trained sign language interpreters in most health care services, so most hearing-impaired women face a communication barrier. The ones who were trained in sign language transferred to other departments or left their jobs, so no new staff has been trained.

The last conclusion that one can obtain from this study is that women with disability are not gettingthe required care, support and attention from their families during the intrapartum period because, as in most of the health care services, attendants, families of the laboring women aren't allowed to visitthem during labor because of privacy issues, lack of private rooms for laboring mothers.

9. Recommendations

Women with disabilities do not have easy or equitable access to maternal healthcare. Improved allocation and management of resources are needed to expand access to healthcare for this vulnerable population. As a result, healthcare facilities should conduct building audits to determine which areas require adjustment and modification, such as adding elevators and rumps to buildings, reducing the number of stairs, and allocating at least one separate toilet that is comfortable for wheelchair users and physically impaired women, relocating and placing serviceareas nearby. If feasible, provide mother and child health services on the ground level,making it accessible to people with all forms of disabilities. In addition, each healthcare institution should enable at least one attendant to be there with the laboring mother, especially for those withdisabilities. Allocate a focus person who provides information and directs people where to go, as well as readable, essential, and simply understanding direction sign boards.

Furthermore, health providers should be trained and educated on how to appropriately approach peoplewith disabilities and how to deliver maternal health care with compassion, respect, and care. Thisongoing training should include all levels of health care providers about disability-related information.

Also, the health minister should collaborate with various disability organizations to provide signlanguage training to all levels of health care providers and non-health professionals working in health care facilities. Providing hearing aids and mobility aids increases rehabilitation centers and makes them accessible to all. Also, purchasing accessible beds.

The Ethiopian education minister and the Ethiopian legislation authority must fully implement provisions in the Ethiopia Disability Act regarding education, including the study of disability and related issues in the curriculum of training institutions.

The Ethiopian Ministry of Labor and Social Affairs should strengthen awareness-raising through mass media education, using different communication Media, and providing training and advocacy efforts. There is a need to identify 'champions 'in various government departments.

The Ethiopian government should strengthen efforts to implement the existing legal and policy frameworks for including people with disabilities and address service delivery gaps. It should also provide funding.

10. Strength and Limitation of The Study

Women's lived experiences and narrative accounts were documented in a qualitative research technique that contributed to a pioneering knowledge of the problems women with disabilities encounter in obtaining and using maternity healthcare. This study has tried to uncover the lived experience of women with disability in accessing maternal health care services; it attempted to discover the deep root causes of these problems and discussed with the participants the possible solutions they proposed. This research also tried to involve different stakeholders and tried touncover their thoughts, their views, and the causes of the unmet needs of women with disabilitywith their possible solutions.

The limitation of this study is that the presence of relatives and friends during interviews with women with speech and hearing impairments may have influenced their responses. This study excluded those women with intellectual impairment due to their lack of experience and lack of a checklistto undertake the study.

Abbreviations

WHO-World Health 0rganization
UN-United Nations
CQC-Care Quality Commission
SRH-Sexual Reproductive Health
YPWD-Young People with Disability **UNDP**-United Nations Development Program**FMOH**-Federal Ministry of Health
ANC-Ante Natal Care
ECDD- Ethiopian Center for Disability and Development
PPP-Post-Partum Period **PWD**-People with Disability **HCF**-Health Care Facilities
WWD-Woman with Disability
ENAD-Ethiopian National Association of the Deaf
ENDAPPD-The Ethiopian National Development Association of Persons with PhysicalDisabilities
VCT -Volunteer Counseling and Testing Of HIV/AIDS
OPDs-Out Patient Departments
MCH-Maternal Child Health

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