ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

DEPARTMENT OF MIDWIFERY

POSTGRADUATE PROGRAM

BARRIERS AND ENABLERS FOR WOMEN WITH DISABILITIES TO ACCESS SEXUAL AND REPRODUCTIVE HEALTH SERVICE IN ADDIS ABABA, ETHIOPIA: A QUALITATIVE STUDY.

PRINCIPAL INVESTIGATOR: SEWNET TILAHUN [BSc]

A RESEARCH THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER IN MATERNITY AND REPRODUCTIVE HEALTH NURSING.

JUNE, 2023

ADDIS ABABA, ETHIOPIA

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

DEPARTMENT OF MIDWIFERY

POSTGRADUATE PROGRAM

Name of investigator	Sewnet Tilahun (BSc)
Name of advisors	Endalew Gemechu Sendo (Ph.D., RN, Asst. Professor) Haweni Adugna (MSC, Asst.Professor)
The full title of the research project	Barriers and enablers for women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia: A qualitative study.
Study period	February 20- March 20, 2023
Study Area	Addis Ababa City, Addis Ababa, Ethiopia
Contact address of the investigator	e-mail: sewnet9tilahun@gmail.com phone: +251925406719

MAY,2023

ADDIS ABABA, ETHIOPIA

APPROVAL BY THE BOARD OF EXAMINATION

This thesis by Sewnet Tilahun is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in maternity and reproductive health nursing.

INTERNAL EXAMINER:

Roza Teshome Msc,Assist.Prof _____ _____

NAME SIGNITURE DATE

EXTERNAL EXAMINER:

_____ _____ _____

NAME SIGNITURE DATE

RESEARCH ADVISORS

Endalew Gemechu Sendo Ph.D., RN, Assist. Prof _____ _____

NAME RANK SIGNITURE DATE

Haweni Adugna Msc,Assist.prof _____ _____

NAME RANK SIGNITURE DATE

DEPARTMENT HEAD

Endalew Gemechu Sendo Ph.D., RN, Assist. Prof _____ _____

NAME RANK SIGNITURE DATE

DECLARATION

Letter of declaration

By my signature below, I declare and affirm that this is entirely that this thesis is my original work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis, and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis. This thesis has been accepted as a partial fulfillment of the requirement for graduate degree from the Addis Ababa University, College of Health Sciences, School of Allied Health Sciences, Department of Nursing and Midwifery. It has never been presented and submitted in a whole or in part, in this or any other university for the award of degree, diploma or other qualification certificates.

Student:

Name: Sewnet Tilahun Signature: _____ Date: _____

Research Advisors:

Endalew Gemechu Sendo Ph.D., RN, Assist. Prof _____ _____

Name Signature Date

Haweni Adugna Msc,Assist.prof_____ _____

Name Signature Date

ACKNOWLEDGMENT

First, I would like to thank Addis Ababa University College of health science, School of Nursing and Midwifery for providing me the chance of conducting this thesis. , Secondly, I would like to thank my respected advisors Dr.Endalew Gemechu and Mrs. Haweni Adugna for giving me their time, attention, their constructive and fruitful advice to complete this thesis.

Thirdly, I would like to thank the Ethiopian national association of Blinds and Ethiopian national association of Persons with physical disabilities offices for providing valuable information on the study participants. Lastly, I would like to thank my study participant for their time, willingness, and cooperation in giving detailed information regarding their experiences.

LIST OF ABBREVIATIONS AND ACRONYMS

AAU: Addis Ababa University

AIDS: Acquired immune deficiency syndrome

CRPD: Convention Rights of Persons with Disabilities

ESS: Ethiopian Socio-Economic Survey

FGD: Focus group discussion

IRB: Ethical review committee

HCES: Household Consumption and Expenditure Survey

ICPD: International Conference on Population and Development

PI: Principal investigator

SDGs: Sustainable developmental goal

SRH: Sexual and reproductive health

SRHR: Sexual and reproductive health right

UN: United Nation

TABLES OF CONTENTS

LIST OF TABLES

LIST OF FIGURE

ABSTRACT

Background: Despite having a fundamental right to access medical facilities and programs with similar range, efficacy, and guidelines to those provided to others, people who are disabled still have difficulty accessing sexual and reproductive health care in developing countries, including Ethiopia.

Objectives: This study aims to explore barriers and enablers for women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia, 2023.

Methods: A qualitative phenomenological study was conducted among purposively selected reproductive age (18-49) group women with disabilities living in Addis Ababa who were members of the Ethiopian National Association of Persons with physical disabilities and Ethiopian National Association for Blind. Ten individual in-depth interviews, as well as 2 focus group discussions, were conducted utilizing an interview guide. Data were audio recorded,transcribed verbatim and iomorted to ATLAS.ti 9.The analysis was conducted with thematic analysis by using inductive coding approaches.

Result: Barriers that could prevent an individual from taking the step to seek SRH service which include negative attitudes in communities, structural hurdles in HFs, financial constraints, transportation issues, and lack of information regarding SRH programs. Enablers that made accessing SRH services and care easier include Social support and network, Access to education, Positive providers' attitudes, and women's self-confidence/Assertiveness.

Conclusion and Recommendation: The study revealed that women with disability encountered numerous challenges and some enablers when receiving SRH treatment and care. To address the barriers and encourage enablers, SRH care Guidelines and programs need to take into account women with disabilities, and actions to eliminate economic barriers to service utilization and promote positive interactions with community members and healthcare providers should be implemented.

Keywords: women, disability, sexual and reproductive health, Addis Ababa, Ethiopia.

1. INTRODUCTION

1.1. Background

Reproductive and sexual health were first introduced in the 1994 International Conference on Population and Development as "reproductive health, a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes" (1).

Reproductive health involves the ability to choose if, when, and how often to have children, in addition to the right to a pleasant and safe sexual relationship. It includes the right to adequate medical care, knowledge, and access to legal and moral ways of fertility control, as well as effective, accessible, and accepted methods of family planning (2)(3). Disability is a broad term that encompasses impairments, activity limitations, and participation restrictions. Impairments are difficulties with physiological functions or structures, whereas activity limits are challenges that an individual faces when doing tasks or actions. Participation limitations are challenges that a person encounters daily (4).

People with disabilities are presently estimated to be one billion people globally, or 15% of the entire population, according to the International Conference on Population and Development (ICPD) based on 2010 global population estimates, making them a substantial minority in society (5). Eighty percent (80%) of people reside in low-income nations or remote regions with little or no access to social and health care. Additionally, estimates indicate that there are more women than men with impairments worldwide(6,7). One-fifth of Women who have disabilities live in developing countries and three-quarters of them are also the state of being completely poor (7). Around the world, women with disabilities have low self-esteem, poor health, and education, are excluded from economic empowerment, and are two to four times more likely to face sexual and physical abuse (intimate partner violence, forced sterilization, and/or abortion) than their counterparts (7,8).

In Ethiopia, there is no recent national survey on disability. According to WHO and World Bank report people living with disabilities in 2011in Ethiopia constitutes 17.6 % of the total population (17.6 million). Comparable to a global figure, a large number of people who are disabled reside in

remote regions with little or no access to basic facilities, and 95% of them have been estimated to live in poverty (9). Nearly 7.8 million Ethiopians, or 9.3 percent of the overall population, are estimated to reside with an impairment, based on statistics gathered by the Household Consumption and Expenditure Survey (HCES) 2015/16 and the Ethiopian Socio-Economic Survey (ESS) 2015/16. About 2.2 million people (2.4%) suffer from very serious problems. Around 47,000 people with severe disabilities reside in Addis Ababa, compared to 324,000 in other regions of the country (4).

One of the conventions Ethiopia has accepted and supported to speed up its expansion and transformation goals is the United Nations Convention on the Rights of Persons Living with Disabilities (UNCRPD). According to Article 25 of this agreement, "State Parties accept persons with disabilities have a fundamental right to access the greatest level of healthcare without any discrimination due to their types of disability." (10).

Women with impairments can require particular attention to meet their specific needs. They also require the same basic medical care as women, and they could also require additional treatment to address their unique needs. However, studies have revealed that many disabled women might not obtain healthcare services (11).

1.2. Statement of the problem

Half of the world's population has a problem accessing basic healthcare services, and about half a billion people have been pushed into extreme poverty because of catastrophic health expenses. This is exacerbated for populations that are particularly vulnerable and marginalized, as they face multiple forms of discrimination and inequity (12). According to a recent WHO international report, disabled people account for at least 15% of any given national age cohort. Women between the ages of 15 to 49 who are fertile make up 23.4% of the country's population (24 million) As a result, approximately 3.6 million reproductive-age women with impairments may reside in Ethiopia(9). People with disabilities have identical sexual and reproductive health (SRH) requirements as the general people, but they frequently face obstacles in obtaining the SRH services that are necessary for healthy relationships, prevention, and treatment of STIs (13).

The availability of SRH services for people with disabilities is a significant challenge around the world, including in Ethiopia. Whether due to stigma, an increased risk of violence or abuse, including lack of awareness, unfavorable attitudes among healthcare professionals, inaccessible medical services, or a lack of gathering and analyzing information on disabilities, there were numerous variables in the health discrepancies among those with disabilities experiences (13,14).

Health and development initiatives, such as the 2030 Strategy for Sustainable Development and the quest for universal health care, tend to focus on specific components of sexual and reproductive health rights (SRHR): family planning, maternity care, and HIV/AIDS. In the last few years, all nations across the world have made outstanding progress in these areas; however, the improvements have not been distributed consistently among or across nations, and services are frequently inadequate in scope and overall performance. Furthermore, numerous people across the globe lack adequate access to a comprehensive range of sexual and reproductive health care, and their rights to sexuality and reproduction are not maintained or secured. Thus, to speed up outcomes, SRHR needs to be viewed as a whole, and unaddressed areas have to be fixed, including women with disabilities (16,17). The Convention on the Rights of Persons with Disabilities (CRPD) says that persons with disabilities should have the same range, quality, and standard of free or affordable health care and programs as provided to other persons without disabilities, including sexual and reproductive health (SRH) services (18).

A project document in Zimbabwe revealed that however the presence of the necessary governmental policies and legal structure, most women still suffer barriers to receiving appropriate SRH care because of stigma and discrimination by healthcare providers, usually believed to be infertile. As a result, women with disabilities prefer delivering at home rather than in a health facility(19). In addition to negative attitudes in health care providers, negative attitudes in the community about disability are a significant problem they face every day. As a consequence, individuals find it difficult to enjoy their fundamental rights and freedoms, notably the provision of justice, birth control, schooling, and social awareness activities (20). Violence against human rights also takes place through sexual violence, which leads to unwanted pregnancies and STIs as women lack access to emergency treatment and care (19).

Findings from a study conducted in low and middle-income countries indicated that people with disabilities are frequently excluded from sexual, reproductive, and newborn healthcare, including for prevention and treatment of HIV/AIDS, as a result of the assumption that they are not sexually active and not at risk of infection (21). A document in Nigeria reported that a gap exists between people with disabilities needs for SRH services and their rights to access such services. Nonetheless, result findings prove that negative stereotypes resulting from social norms and beliefs limit PWDs' freedom to exercise their human and sexual rights as well as their capacity to access and use services (22).

To achieve those rights, women with disabilities participation in SRH has to be recognized, and they must be given suitable, readily available information suitable for all ages, create a family, and take advantage of reproductive health (23,24). However, in Ethiopia, there is a limitation of studies on whether those people utilized their rights according to the convection, especially on SRH services.

Although previous investigations have assessed the factors affecting access to and utilization of sexual and reproductive health services by the general women population, few studies have explored the challenges faced by persons with physical disabilities (PWPDs) in accessing these services in Ethiopia. This study aims to know about the barriers and enablers for women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia in 2023.

1.3. Significant of the study

A few programs are currently available to meet the SRH requirements of persons with disabilities in Ethiopia. Understanding their unique needs, challenges and enablers can better inform that the appropriate health providers address their SRH rights. The government and other stakeholders will also be informed by the findings to make sure that policy measures that enhance people with a disability access to SRH services are implemented. As far as our understanding this finding is the first of its kind in Ethiopia and it will serve as a benchmark for further study.

.

2. LITERATURE REVIEW

2.1. Introduction

People who are disabled make up a large proportion of the world's population and are present in every society. Giving priority to the SRH requirements of people with disabilities is critical for securing the preservation and advancement of their human rights, achieving the global goal of development, and establishing an inclusive society. Although the complete picture of SRH difficulties for people with disabilities is not fully evident, it is clear that there are major unmet requirements. Persons with disabilities, like everyone else, require knowledge of SRH. To do so, individuals must have the ability to make reproductive decisions for themselves. They must have the same access as everyone else to programs, services, and resources that assist them in making decisions(25).

In this section, the relevant literature associated with the barriers and enablers for women with disabilities to access sexual and reproductive health services is reviewed. Sexual and reproductive health services utilization could be affected by different barriers. Sociodemographic, Barriers and enablers are believed to be some of the barriers and enablers that could affect SRH utilization among women with disability.

2.2.Sexual and Reproductive Health Services Utilizations

In a study conducted in Nepal, investigators examined the frequency women with disabilities utilized facilities for sexual and reproductive health, and they noticed that the rate was only 15%. Just 12 percent of people had ever utilized maternity or infant care; 11% had ever utilized birth control services; 0.3% had ever received preventative or suitable infertility therapy; and 0.5% had ever used safe abortion and post-abortion care. They had never accessed any SRH services for HIV/AIDS or other sexually transmitted infections (26). According to research on Ghanaian in-school students with disabilities who utilize services related to sexual and reproductive health, approximately seven out of every ten respondents had ever used SRHS (27).

According to a study conducted in southern Ethiopia, variations between adolescents who have disabilities and those without disabilities in the use of reproductive and sexual health services and

related characteristics were 32.2% and 51.7%, respectively, in adolescents who are disabled and those who are not disabled. This demonstrates that there is a substantial difference in the prevalence of SRH use among teenagers who are disabled and those who are not disabled. This discrepancy could be explained by adolescents who are disabled having insufficient information about SRH services, as well as inequitable societal norms that result in an absence of knowledge and lack of awareness regarding adolescence, sexual orientation, and rights for humanity (28).

A study conducted in Addis Ababa, Ethiopia, on the SRH knowledge and attitudes of young people with disabilities, found that just 26.1% (n = 111) had ever used SRH service(29).

2.3. Sociodemographic Background

Finding from Ethiopia on the SRH knowledge and attitude of young individuals with disabilities found that the level of SRH awareness grew with each additional year of age. Several other factors explain why adolescents may not require SRH services as frequently as adults, despite the notion that healthcare-seeking behaviors differ between youth and adults according to their degree of understanding (29). In contrast, findings from a study on a review of disability inclusion for refugees in Ethiopia show that older women with impairments were substantially more excluded than older women without disabilities. Fifty percent of elderly women with disabilities stated they were never consulted in the camps and had no idea how to make a complaint or provide feedback on services. The research states that "this highlights the need for gender-specific considerations in engaging with older people, as well as in complaint and feedback mechanisms."(30).

Poor income and low education rates were assumed to be the primary barriers preventing people with disabilities from getting reproductive health care information and services. Their low levels of education exacerbated their financial condition due to their difficulty getting better jobs. It was especially difficult for some people with disabilities to obtain full-time employment because they had no formal education. Many disabled people in countries that have low and medium incomes confessed that they could not finish high school, and some people were unable to attend school due to poverty(31).

Many healthcare professionals discussed the crucial role parent play in promoting or limiting the use of SRH care, pointing out how the stigma surrounding persons with a disability sometimes

leads to parents "hiding" relatives of them who are disabled, which is detrimental to their health and well-being (32).

2.4 Barriers to Sexual and reproductive health services for Women with Disabilities

In the quest for sexual and reproductive health care among individuals with disabilities, several barriers and challenges have been noted in the literature. The barriers are the factors that could prevent an individual from taking the step to seek SRH service. Notable among these challenges are financial difficulties (transportation expenses to a health care center, cost of health services, and lack of any special treatment at the clinic), physical barriers, provider attitudes and discrimination by health professionals, lack of medical equipment adapted for usage, and the problem of communication (32–34).

2.4.1. Structural barriers within health facilities

The provision of health care needs to be prepared to meet the requirements and everyone's ambitions for seeking access to health care services. This means that patients should be able to access any services they require without any barriers. structural lor barrier of health care prevents everyone, particularly people with disabilities, from accessing services appropriate to their impairment type. Because of physical obstacles, services are inaccessible to users of wheelchairs and walking aids, as well as to people who are blind. As a result, people with visual and physical impairments do not have the same access to health care as people who are not impaired (35).

Furthermore, a qualitative study conducted in Senegal exploring the utilization of sexual and reproductive health services and knowledge for young women who are disabled stated that physical inaccessibility within healthcare facilities is a significant barrier. Among those the greatest significant hurdle to utilizing SRH services was the absence of accessible ramps and elevators. Participants reported severe difficulty getting into health facilities and subsequently going to the examination, laboratory, and other medical centers (36).

Moreover, in a study conducted in the Kibuku district of Uganda, it was also found that there were no beds suitable for their needs in health facilities. They experienced difficulties getting on and off. The beds used for clinical assessment**,** labor and delivery, and also postnatal care were too elevated for them, making it difficult for them to get on and off. They required assistance to use

the beds, but it wasn't always available, especially for single women with impairments who also had little to no partner involvement (37).

2.4.2. Transportation difficulties and health facility distances

According to a study conducted in Zimbabwe on barriers experienced by women who are disabled in utilizing sexual and reproductive health services, most participants complained that clinics and hospitals are far from their environment. Some said that they had to walk considerable distances to go to the nearest clinic. For people with physical disabilities, accessing the nearest health institution was costly because public transportation required them to pay for both themselves and their supporters. In some situations, they pay for their wheelchairs as well(20).

Furthermore, a qualitative study conducted in Senegal exploring the utilization of sexual and reproductive health services and knowledge for young women who are disabled revealed that healthcare institutions were cited as being located far away, and troubles using transportation options were mentioned. Due to the hospitals' distance from their homes, several women said that transportation costs are significant. "If you take a bus, they compel you to leave, claiming that your wheelchair has no place on the vehicle." Also, one woman experienced discrimination with public transportation while full-term pregnant and wanted to go to the clinic for a checkup(36).

2.4.3. Financial barriers

According to a study on problems in utilizing sexual and reproductive health services for people who are physically impaired in Uganda, inaccessibility to SRH services is also connected with high service costs. The majority of respondents stated that healthcare services are expensive and that many PWPDs could not access them given their minimum incomes. A key informant stated that the cost of prenatal, antenatal, labor, and delivery care is a significant problem. Most disabled individuals struggle to pay for medical treatment, and their rights are constrained (38).

Also, a study conducted in Zimbabwe noted in their study that health centers, including those controlled by the state, and municipal governments impose consultation fees ranging from $5 to $20. Clients are responsible for paying for the services and supplies they get besides the consultation cost (20).

A qualitative study conducted in the Philippines on sexual and reproductive health services for women who are disabled with health care professionals indicated that several factors specifically undermining women with disability's access to SRH services and information, including financial barriers that women with disabilities may face as well as insufficient material, health care provider, and financial resources, are obstacles in the provision of SRH services (32).

2.4.4. Healthcare Providers' Attitudes/lack of Orientation

A study conducted, on problems in utilizing sexual and reproductive health services for people who are physically impaired in Uganda indicated that the negative attitudes of health care personnel are the significant barrier that people who are disabled confront while receiving SRH services. This is generally exacerbated by cultural views and expectations that a person who is disabled should be infertile. This fact is supported by the following quote: „You know, it's almost as if women who are physically disabled should be infertile." When I go for an antenatal checkup, the healthcare provider looks at me as if I've done something bad! They can be unhappy with me at times, We don't like how the community treats us including Health Care Providers.”(38).

A qualitative study conducted in the Philippines on sexual and reproductive health services for women who are disabled with health care professionals indicated that when care providers lack training on how to fulfill the interests of women who are disabled or have negative views toward disability, the provider may be unsuitably treating women who are disabled and show unnecessary thing. Reports of verbal abuse were among the inappropriate behavior descriptions. Communication problems were also a specific challenge for healthcare providers providing SRH services to women with disabilities. Participants stated how communication issues irritated care providers, leading to undesirable outcomes for women who are Disabled (32).

Findings from a study conducted in Senegal on barriers and enablers for people who are disabled to utilize sexual and reproductive healthcare services revealed that healthcare providers discriminate against clients based on their disabilities. Also, these studies revealed that young people who are disabled experience a severe lack of SRH service information. This finding is further illustrated by this quote: "I never thought of going to see a health professional for advice related to sex, because to me it's something taboo. I have never avoided a health facility because I did not know about it. I have no information about these facilities.”(39). This finding is further

supported by the following statement: "Sex is something prohibited to me, so I had no intention of asking a health professional for guidance regarding sex. Because I know most disabled individuals struggle to pay for medical treatment, and their rights are hampered."

2.5. Enablers to sexual and reproductive health services for women with disabilities

A study was conducted in the Ashanti and Brong Ahafo regions of Ghana to examine the enablers and barriers faced by women with a blind in utilizing SRH services and care. The enablers are caregivers' support and the positive attitude of healthcare providers when accessing treatment at the health facility (34).

Individual enabling characteristics such as education, income, and support networks were found to be consistent predictors of accessing SRH services in the studies examined. When compared to non-disabled people, PWDs are less likely to be educated and less likely to be employed (40). While a study on the SRH knowledge and attitudes of young people who are disabled conducted in Ethiopia found that a low level of schooling is substantially connected with low SRH awareness. In these studies, positive outcomes are recorded through the involvement of family, friends, and the community. One of these is the practical and emotional support that family members give to disabled people (29).

Also, a nationwide study in Bangladesh on the effect of education on sexual and reproductive health service access for persons who are disabled suggests that education significantly boosts the use of SRH services, including birth control, prenatal care, labor and delivery care, and postpartum care. Interestingly, for people with disabilities, these findings also show that as education increased from primary education to secondary education to higher levels, SRH service utilization increased and advanced (41).

A study conducted in Ghana on accessing sexual and reproductive health services for people who are disabled found that young people with disabilities who had health insurance had a higher probability of using SRHS than those who did not (27).

3. OBJECTIVES OF THE STUDY

3.1 General Objective

To explore barriers and enablers for women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia, 2023.

3.2. Specific objectives

- Explore barriers for women with disabilities to access sexual and reproductive health services utilization.
- Explore enablers for women with disabilities to access sexual and reproductive health services utilization.
- Describe recommendation of participants for enhancing sexual and reproductive health services utilization.

4. METHODS

4.1.Study area

The research study was conducted in the capital city of Addis Ababa, where the Ethiopian National Association of Persons with Disabilities (ENAPD) and the Ethiopian National Association for the Blind (ENAB) are headquartered. Based on the 2007 Ethiopian Housing and Population Report data, it is administratively structured into eleven sub-cities and 116 woredas, occupying a total area of 540 square kilometers. It is estimated that the capital city has a population of 2,739,551, with 47,000 of these people living with some form of disability.

The study involved members of these two organizations. Established in 1960, ENAB was formed with the key mission of protecting universal human rights, equal opportunities, and the full participation of blind people in the country. The organization is the first association of persons with disabilities in Ethiopia, and currently, it has more than 12,000 active members and 32 branch offices in 5 regions and 2 administrative cities. The second organization, ENAPD, was formed in 1985 and now has a total of 6831 members in Addis Ababa, of whom 500 are women. It is located on Churchill Road, next to the Eliana Hotel, in Addis Ababa, Ethiopia.

4.2. Study period

The study was conducted from February 20- March 20, 2023.

4.3. Study design

In the study, a phenomenological approach was used to explore barriers and enablers for women with disabilities to access sexual and reproductive health services.

4.4.Source population

All women with disabilities residing in Addis Ababa city, Ethiopia.

4.5. Study population

The profile of the study group in the range of reproductive age (18–49) of women with disabilities who are members of ENAB and ENAPD.

4.6. Inclusion and exclusion criteria

4.6.1. Inclusion criteria:

Women who were members of one of the two organizations and who fulfilled the following criteria were included in the study:

Who had received SRH services before the study

Within the age range of 18-49 years

Lived in Addis Ababa for at least 6 months.

Provide written consent to participate in the study

4.6.2.Exclusion criteria:

Those women who are unable to communicate and respond to questionnaires were not included in this study.

4.7.Data collection tool and procedure

In-depth one-on-one interviews and FGD were conducted by the principal investigator along with a trained female research assistant, collecting all evidence materials in audio format. An interview guide was used to outline the open-ended topics in Amharic. The researchers performed preliminary interviews with two participants ahead of the main interviews with the group. The interview procedure and questions were modified in line with the pilot interviews.

The interview was focused on participants' descriptions and experiences of SRH service. An interview guide was used that cover questions on issues related to barriers and enablers for WWDs who face challenges in their daily lives while seeking SRH services and care, including sociodemographic character, structural barriers in the health facility, transportation suitability, financial status, healthcare provider attitude, and support network. Participants' descriptions and experiences of SRH service have been exposed in detail through the interviews.

Study participants comprised women with disabilities who are members of one of the two associations currently. Participants who match the inclusion criteria and can offer detailed information were chosen using a purposeful sampling procedure. All participants were selected intentionally after a survey was conducted based on the experience of SRH service utilization.

Ten participants were included in the in-depth interview, 5 were women with visual impairments and 5 were with physical impairments. The interviews were conducted in a private class, in the organization. Each interview took about a maximum of 40 minutes and a minimum of 20 minutes. Women who were included in an in-depth interview were not involved in FGD and vice versa.

The FGD data was collected from two FGD groups. The FGD groups formed in the study area; each group consists of 6 (FGD with physical disabilities) and 8 (FGD with the blind association) disabled women. Each FGD lasts approximately 60 minutes.

The interview was recorded and a field note was taken. All the output materials from the interview were audio-recording whereas the data are well privately placed digitally by the principal investigator to protect the privacy of the participants. Data saturation was considered for data collection. When additional information failed to produce any new emergent codes or themes.

4.8. Operational definitions

Reproductive health services: specifically taken into account in our investigation were Family planning use, antenatal care use, Facility-based delivery services, Safe abortion care, and access to information on sexual and reproductive health services.

Women with disability: particularly considered in this study will be women with physical disabilities and blind.

Physical disability: is a difficulty that develops in the use and movement of physical components due to the structure and function of bones and joints, as well as problems with the nerves and muscles that control them (42).

Barriers to SRH service are the factors that could prevent an individual from taking the step to seek SRH service(33).

Enablers of SRH service which supports and facilitated utilization of SRH services (34).

4.9. Trustworthiness

To ensure the validity of the findings, four approaches were taken into consideration. These include credibility, transferability, dependability, and conformability.

4.9.1.Crediblity (Truth Value)

Before the actual data collection, the investigators arrived at the study site and get familiarized with the study setting, and create a rapport with relevant people in the association. The principal investigator (PI) also maintained continuous interaction and engagement with the study site and respondents, which reduced informational alteration and allowed for a better understanding of the context of the research.

The investigator also used audio recordings and field notes during interviewing. In addition, triangulation of the data (in-depth interview and FGD) was used including the study's consistent use of the same interviewing guide.

4.9.2. Transferability(Applicablity)

The researcher gave a deep description of the research context, technique, respondents, and result to ensure transferability. Additionally, a deliberate selection of participants was employed to focus on those who could provide comprehensive information.

4.9.3. Dependability (Consistency)

This was accomplished by keeping audio recordings of participant interviews, verbatim transcriptions of the notes taken during the interviews, and cross-checking the process. Additionally, all data collection instruments, raw data, analysis codes, and conclusions were sent to researchers who were not involved in the research for an external audit. In addition, the result and discussion of this study were supported by relevant and directly related literature.

4.9.4. Conformability (Neutrality)

By carefully going over the interview transcripts, comparing the codes with the raw data, and repeatedly cross-referencing the findings with the opinions of the participants, it was made sure

that reflexivity was maintained and that the investigators' perspectives did not influence the study data. For external validation, this approach was supported by the supervisor and other academics who have experience in qualitative research.

4.10.Methods of data analysis and Processing

Analysis of the data was started simultaneously with data collection and emerging ideas and new question was added throughout data collection. Emerged codes were thematically analyzed inductively. Data from the audio recording were transcribed verbatim concurrently with data collection in the language of an interview where Amharic. Transcribed verbatim was translated from Amharic to English. Afterward, data were checked by qualitative experts for consistency between transcripts and audio recordings. Data were coded line by line after imported to Atlas ti9 software including finding from notes taking, to aid the process of coding. Primarily the principal investigator carried out coding and then the main advisors revised and checked for clarity and consistency of the code. Identified codes, according to similarities and differences, were allocated into subthemes. Similar sub-themes were grouped into themes. Finally, the sub-themes and codes were determined as the expression of the latent meaning of the text. Then, the views shared by respondents were used as quotes to support the points in the study.

4.11. Ethical considerations

The study was started after full approval and Ethical clearance to conduct this research was obtained from the School of Nursing and Midwifery, College of Health Sciences, Addis Ababa University. Administrative Permission was granted after a written request was made to participating disability association. Before participants signed the consent form, which was written in Amharic, the researcher ensured that participants understood the information given at the level of their understanding. After informed written consent is obtained from all participants, the right to refuse an answer to a few or all questions is valued. The voluntary nature of participation in this study was underlined. To ensure anonymity and Confidentiality the following measures were taken; participants assured that all of the information given by them would only be used for the study. The researcher made sure that the collected raw data were kept safe and locked up by password, the names of the participants were not written in study records, and data were reported in a manner that does not identify or link the participants with the information.

4.12. Dissemination of Study Findings

The results of this study will be submitted and presented to the School of Nursing and Midwifery at Addis Ababa University's College of Health Sciences. Finally, attempts will be made to publish portions of the research findings in reputable local and/or international journals. Workshops and seminars will also be used to disseminate the findings.

5. RESULTS

Two sections in these findings explore barriers and enablers for women with disabilities to access sexual and reproductive health services. They are presented as follows: The first part describes the socio-demographic and obstetric characteristics of respondents, and the second part describes the emerging themes and subthemes.

5.1. Sociodemographic characteristics

The researcher recruited 24 disabled women in total for this study. In contrast to the 11 (45.83%) women who have physical impairments, 13 (54.16%) of women have vision impairments. The mean age of participants was 32 years and ranges from 22-48 years. Sixty-six percent were single and 29% had unemployed. Eighty-three percent of the participants had college and above. The sociodemographic and obstetric information of those who participated in these studies is displayed in the table below.

Table 1 Socio-demographic and obstetric characteristics of women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia, 2023.

Socio-demographic and obstetric characteristics	Category	Frequency
Age	18-24 years	1
	25-34 years	14
	35-49 years	9
Religion	Orthodox	18
	Muslim	1
	Protestant	5
Marital status	Single	16
	Married	7
	Divorce	1
Occupation	Governmental employ	7
	Private employ	9
	Housewife	1
	Unemployed	7
Education	Primary	1
	Secondary	3
	Collage and above	20
No of children	0	12
	1-2	12
Hx of abortion	0	8
	1-2	2
Family planning use	Post pill	3
	Depo Provera	2
	Implant	3
	none	2

5.2. Emerged Themes

Following the analysis of the data from the in-depth interviews and FGD, three main themes that are in line with the objectives of the research emerged: barriers for women with disabilities to access SRH services, enablers of women with disabilities to access SRH services, and recommendations for improving SRH services. The topics have been identified to provide in-depth descriptions of the factors preventing and facilitating the use of sexual and reproductive health services by women with disabilities.

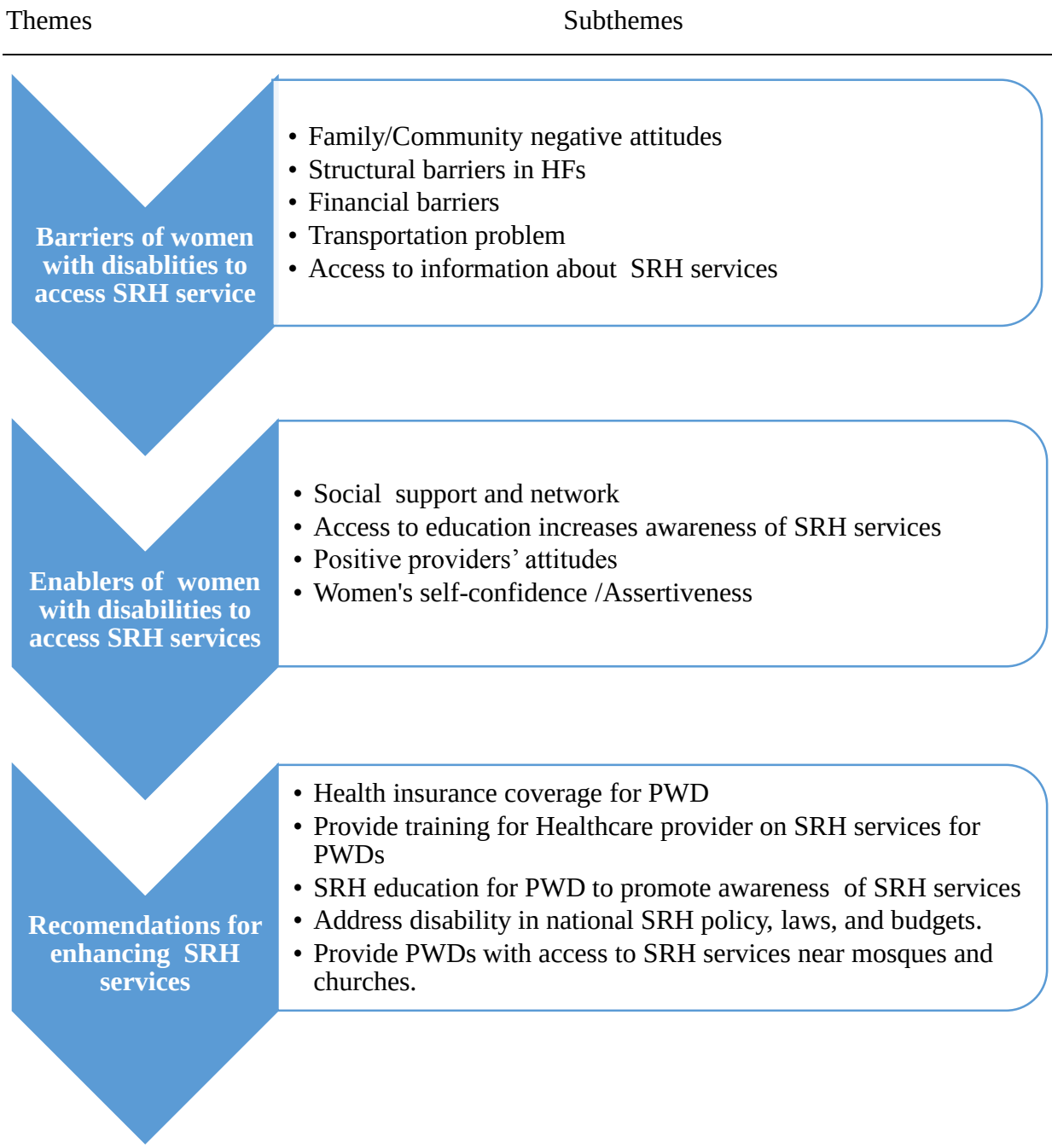

Figure 1 Schematic presentation of emerged themes and subthemes of sexual and reproductive health services Barrier and enabler among women with disabilities in Addis Ababa, Ethiopia, 2023.

Theme1: Barriers of women with disabilities to access SRH services

The first theme that emerged in this study analysis was the Barriers to women with disabilities accessing SRH services which contain five categories. There are different obstacles experienced by women with a disability while using sexual reproductive health services. In this study, it was found that most of the women with disabilities who were interviewed cited negative attitudes in families and communities, structural hurdles in HFs, financial constraints, transportation issues, and lack of information regarding SRH programs as their top challenges.

Sub-theme 1: Family/Community negative attitudes

Most participants reported that there is a general lack of awareness about disabilities and SRH services in the community. Nearly all participants disagreed with the community's assumptions that women's disabilities prevent them from having sexual activity, getting married, or having children.

"The majority of the community members doubt our ability to have children and raise them appropriately…" ***[Interview 3, age 26]***

"…Many people in the community believe a blind woman gives birth to a blind child…and she is not encouraged to marry and have children. …" ***[FGD 1, participant D]***

"*…disabled women engaging in marriage as compassionate activity provided to them by their husbands. For example, I am disabled women who have been married, and many people in my community think that he married me and he is such a good person doing so...*" ***[FGD 2, participant A]***

Sub-theme 2: Structural barriers in HFs

Participants claimed that it was very hard for them to enter health facilities and then get to consultation rooms, which are inaccessible to disabled women. They had difficulty using the stairs to enter buildings in healthcare institutions, and elevators mostly did not work. This was especially problematic for people with physical disabilities who use wheelchairs there isn't a ramp built with standards.

The mothers who had problems moving around asserted that hospitals lacked beds that were appropriate for their needs. They required assistance to use the bed to get essential SRH services, including physical assessment, labor and delivery, and other maternal care.

"PWDs are not included in the healthcare system in our country. Consider the structures in the health facilities, for example. Take a look at the architecture of the medical facilities. Lack of ramps, adapted examination tables is a major challenge in the HFs…..etc." ***[Interview 5, age 30]***

*"We [disabled women] all wait in the long line at the medical facilities, just like everyone else. In these facilities, it can be very difficult for someone like me to use the restroom****…." [Interview 2, age 26]***

Sub-theme 3: Financial barriers

The other barrier many times arose for most participants was the issue of finances. Women from blind associations noted concerns about the low financial resources (unemployed), our family is not supportive to cover the cost because they consider the service not necessary for us. It may be notable that seven out of twenty-four respondents were those without employment currently. People with better economic capacities can get better services as they can get the service effectively handling pertaining costs otherwise, it is difficult to handle the cost in order to utilize the service.

The participants indicated that they suffer economic difficulties starting from transportation costs up to utilization of service, as a result of their lack of resources and insurance coverage. Some of the participants claimed that these challenges impeded them from getting medical care, including obtaining medication, Ultrasound examination, and laboratory findings that were recommended by caretakers.

"*When I was grade eighth student I got pregnant for the first time. And I had to get rid of the baby at the time. : It was Mary Stoppe around the Merkato area. I remember it was around 130 birr for the entire cost of the procedure. My friend paid for the cost which was a big amount for me and it was quite difficult to face"* ***[Interview 1, age 34]***

"Since most PWDS have low incomes, they cannot afford to purchase even basic medications or sanitary products…" ***[Interview 5, age 30]***

"…But I lack the necessary financial resources. I believe that having health insurance is essential…." ***[Interview 13, age 29]***

Sub-theme 4: Transportation problem

Moving from place to place in the city is highly challenging for many WWDs due to the accessibility of the transportation system including how to board the buses and taxis as well as the increasingly mounting prices for transportation to travel. Even the majority of bus drivers are unable to use bus ramps, and the majority of taxis are not accessible to the disabled. The expense of transportation is extremely high for disabled women because we are low-income producers in society. The city administration does set a lower price with the special status. One woman spoke about a discriminating incident she had while taking a taxi:

"For disabled women, transportation services are uncomfortable. Getting into a taxi to go to SRH services is challenging… ***[Interview 12, age 26]***

*"I can tell you from my experience that because of my disability, I rely primarily on contract taxis, which has been quite expensive for me…Sadly, the public transportation system was not designed for people with disabilities like me…"****[Interview 7, age 35]***

Sub-theme 5: Lack of Access to Information about SRH Services

The degree of knowledge or information about Reproductive health services (RHS) varies among participants. Some of the participants described that there are gaps in accessibility issues on SRH information. There is no situation that deals with SRH service issues because most of the community(family, health care provider) believed not necessary for them. Women from the blind association claimed that there is no way that they could access the information since there is a lack of aid (brail) that assist them also they mentioned that there are no materials ready with audio, is it possible to get a doctor or a nurse that can speak sign language, there is no information on SRH that is prepared with brochures or materials centers.

*"We are not getting help from family members, and even our family members are not to be supportive of us. It is also impossible to discuss reproductive health issues. Most family members worry disabled women might confront an unplanned pregnancy and become victims of STD"****[FGD 1, participant E].***

"…I don't think that women with disabilities have easy access to SRH information, and I don't think that women as a whole have been sufficiently reached by it either." ***[FGD 2, participant F]***

"*I have no knowledge of birth control I was not aware of anything back then. That's why I was wrongly involved in something horrific (abortion) that could have put my life in danger"* ***[Interview 1, age 34]***

Theme 2: Enablers of women with disabilities to access SRH services

The second theme that emerged in this study analysis was the Enablers of women with disabilities to access SRH services which contain four categories. Enabling ranges from the role of Social support and network, Access to education increases awareness of SRH services, Positive providers' attitudes, and women's self-confidence /Assertiveness in ensuring access to SRH services.

Sub-theme 1: Social support and network

Social support and network structure as key elements for PWDs to have accessible SRH according to the participant's testimony including family support, friends support, presence of mass media, and being members of the association. The support should include finances, mobility aid, information, communication, and safeguarding for WWDs. However, most of the women who are disabled didn't get support.

Women from the blind association noted that training prepared by Women Sector Department concerning the issues of sexual reproductive health for disabled women, and they had previously attended the training. Being a member of the association helped them to access the information and get the SRH service.

"My family and friend were supportive of me. They used to accompany me to ANC check-ups… People who have better financial standing can access better SRH services, including HF deliveries... ***" [Interview 10, age 42].***

"We receive SRH information through our Women's Association, where many doctors visited and offered services related to sexual and reproductive health, including the use of contraception….." ***[FGD 1, participant E]***

Sub-theme 2: Access to education increases awareness of SRH services

In these studies, education or knowledge has a great impact to utilize SRH service and also provides much information concerning the service. Educated women are advantageous compared to those with less education as knowledge provides much information concerning the issues, the advantage of utilizing the service, and its outcomes. For women who are less educated are the victims of a lack of awareness.

" I believe education is information everything we have learned when we were kids until university. I know how to read to get information from books." ***[Interview 5, age 30].***

"*I have a BSc degree, and it has been incredibly beneficial. "* ***[Interview 2, age 26].***

Sub-theme 3: Positive Providers' Attitudes

Despite the problem with accessing the SRH, some participants have acknowledged that they have a very well-built personal relationship with caregivers who eagerly support them.

"I had a positive experience, and the provider was quite helpful when I delivered my baby in the facility..." ***[Interview 1, age 34]***

Sub-theme 4: Women's self-confidence /Assertiveness

Despite numerous outside influences, some of the women's stories revealed that an internalized perception of themselves as acceptable clients is the main point to utilizing SRH services like the general women. Women from blind association noted that humans have been created in opposite sex male and female, and disabled people have been created in the same manner that one person to be born, grow, confront death, and confront the same life situations so, they can have normal sexual reproductive health, they are part of the community giving birth to children and raising them. Any disabled woman shall be ready to become reproductive health services.

"I believe that for a woman to effectively utilize reproductive health services, she must be educated and self-confident……" ***[Interview 7, age 35]***

Theme 3: Recommendations for enhancing SRH services

Recommendations for improving SRH services, which fall into five categories and include providing health insurance coverage for PWDs, training healthcare providers on SRH services for PWDs, educating PWDs about SRH services, and addressing disability in national SRH policy, laws, and budgets, emerged as the third theme in this study's analysis, and making SRH services available to PWDs close to mosques and churches. It facilitates a disabled woman's future utilization of sexual and reproductive health services.

Sub-theme 1: Health insurance coverage for PWD

The majority of the findings demonstrated the influence of financial capacity on the use of SRH services in this study. According to the participants, spending money on medical care has a big impact, especially on disabled women. Insurance coverage could cut the price that disabled individuals are expected to pay for SRH services and increase uptake.

"We benefit from having health insurance, but I cannot tell you detailed issues I have not enough knowledge regarding the issue. But, it was better if we have had medical insurance ...." ***[Interview 3, age 26]***

"...But I lack the indispensable financial resources. I believe that having health insurance is essential to get better services...." ***[Interview 13, age 29]***

Sub-theme 2: Provide training for Healthcare providers on SRH services

Unjustifiable lack of access to SRH service was caused by the unethical behavior and negative attitudes of the health care providers towards women with a disability as some of the participants mentioned. Nearly all participants recommend Training and awareness must be given to the health community on what is disability, the types of disability, and how to interact with women who are disabled.

"Persons with disabilities have the same needs for SRH services as everyone else. But people with disabilities regularly have their needs neglected by the providers. They need to be trained to address those needs." ***[Interview 5, age 30]***

*"The needs of people with impairments are routinely disregarded by the providers …., they must undergo training**…" [Interview 10, age 42]***

Sub-theme 3: SRH education for PWD to promote awareness of SRH services

Sexual and reproductive health education and awareness creation are necessary to ensure access to SRH services for women who are disabled. Some of the participants said that difficult to access SRH education and most of the participants recommend availing SRH education to promote awareness.

"*My friends and I took part in the SRH training and learned a lot about the services that are offered. But a rural woman finds it challenging to obtain SRH information, so it is important to address them**…" [Interview 4, age 26]***

*"There are no pamphlets developed for PWDs that provide information on SRH services. Accessing SRH information through leaflets in HFs on SRH Services could be very helpful for this set of people. Using phone platforms like smartphones, radios, disability corner, and short-digit numbers can also be helpful for SRH information." **[Interview 5, age 30]***

*"I argue that increasing awareness must come first to increase the number of disabled women who benefit from SRH's programs…" **[Interview 7, age 35]***

Sub-theme 4: Address disability in national SRH policy, laws, and budgets

For the successful delivery of SRH services to women with disabilities, national policies, laws, and budgets address or include disability. Government work on policies, proclamations, international laws, and working collaborate with health care givers and empowering women with disabilities since its double challenge, sex by itself plus disability. Many participants expressed they need support all round and recommend addressing disability in national SRH policy, laws, and budgets.

*"…I learn about SRH through my family, and my sister who is a doctor. Little is done by the government on this matter. Is it possible to assign a nurse or medical practitioner who communicates sign language at the HFs? **…** Assign sign language interpreters available at the HFs" **[Interview 5, age 30]***

Sub-theme 5: Provide PWDs with access to SRH services near mosques and churches

In our country, there are a lot of disabled people who reside close to mosques and churches living in poverty and dwelling. They are unaware of SRH service while they are vulnerable or at risk of non-partner sexual violence day to day and they cannot afford SRH service due to low awareness, financial difficulty, and fear of discrimination. Some participants suggested offering SRH services close to mosques and churches.

"*I propose that reproductive health services be made available to PWDs who are poor and live near mosques and churches."****[Interview 12, age 26]***

*"The government and stakeholders should take action concerning the sexual and reproductive health of individuals with disabilities to promote SRH service accessibility."****[Interview 5, age 30]***

6. DISCUSSION

The current study aimed to explore the barriers and enablers for women with disabilities to access sexual and reproductive health care. The study identified barriers and enablers for women with disability to access sexual and reproductive health services in three organized themes: barriers of women with disabilities to access SRH services, enablers of women with disabilities to access SRH services, and recommendations for enhancing SRH services.

Based on the results of these studies, the majority of participants encountered substantial challenges while trying to access SRH information and services, in line with another finding (32–34). Although the UN Agreement on the Fundamental Rights of Persons Who Are Disabled ensures that people with disabilities have the opportunity to utilize "the same range, quality, and level of accessible or affordable medical care and programs as given to the general population" (18).

Family/Community negative attitudes were reported by nearly all participants as a major barrier to utilizing SRH service and care. They claimed there is a lack of awareness in the community related to disability and SRH service. They think we even have no sexual desire, are not active in sexual activity, are not capable of marriage, or are not capable of having children and raising them due to our disability. Women with disabilities need support from the community at large, their families, spouses, and health care providers. This acceptability influences the way communities and parents view the need for SRH services associated with the WWD. These studies revealed that WWDs are frequently discriminated against by family members, as well as SRH care providers. This has been linked more to the communities' inability to understand the disabilities and their ability or interest in SRH care than the disability itself. This result is in line with the findings from low- and middle-income countries, Uganda(38), and the Philippines (32). The possible reason for the emergence of this negative attitude might be due to lack of awareness or knowledge about disability and SRH services.

Nearly all participants in these findings recommend training and awareness must be given to the health community on what is a disability, types of disability, and how to communicate with women with disabilities. Additionally, training needs to emphasize how crucial it is to provide everyone, irrespective of circumstance or disability, with access to sexual and reproductive health care.

According to the participant's perspective**,** structural barriers in HFs are the main concern during the utilization of SRH service. The facilities in several organizations are unsuited for WWD. For instance, many facilities do not have ramps that are built to the required standards for people with disabilities. Accessibility is significantly more difficult if there are stairs, and lifts frequently fail to function. This was especially challenging for people with physical disabilities who use wheelchairs. While the health care delivery system needs to be prepared to meet the needs and interests of all people seeking access to health care, It refers to the client's need to access all services they require without any constraints. Structural problems in healthcare facilities prevent all people, particularly those who are disabled, from accessing services appropriate to their impairment type (35).

Analogous to these findings, studies in many countries show similar Structural barriers in HFs for PWD to access SRH service. Uganda(38), Senegal (36). This study emphasizes the importance of reassessing and improving the physical structure of healthcare facilities to account for various disabilities.

From these findings, some participants recommend that disability needs to be taken into account in government sexual and reproductive health policy, regulations, and funding for services to be effectively delivered. For women with disabilities, national policies, laws, and budgets address or include disability. The government works on policies, proclamations, and international laws and collaborates with healthcare providers.

Women with disability reported financial challenges when accessing SRH services in this study., as demonstrated in various environments, such as Ghana, (34) Zimbabwe,(20) Senegal(36), and the Philippines, (32) in which the financial burden of handling disabled women was high. In Ethiopia, women from blind associations noted concerns about the low financial resources, including the lack of insurance coverage to cover the need for SRH service. It may be notable that seven out of twenty-four respondents were those without employment currently. This is due to Discrimination based on disability type may result in excessive unemployed as participants' history showed but not deeply probed. Since disabled women have economic obstacles to receiving treatment, these challenges might be exacerbated for disabled women, who experience more obstacles in finding jobs and are more likely to be unemployed.

From these findings, participants recommend providing health insurance coverage for WWDs. Insurance coverage could cut the price that disabled individuals are expected to pay for SRH services and increase uptake.

The findings of this study show that moving from place to place in the city is highly challenging for many WWDs. They frequently fail to reach the healthcare facility without assistance. This restricts their access to healthcare facilities; one participant in particular thought that transportation costs posed challenges, particularly when paying additional costs for assistance. Reliance on others to accompany them to medical centers influences women who are disabled's ability to obtain private medical attention.

A participant from the blind association said that there will be no secretive issues, even if I ask for help to direct me to my attending physician's room. Also, a participant with a physical disability said that she faced a discriminatory incident while taking a taxi. According to Article 25 of the agreement, "State Parties acknowledge that individuals who are disabled possess the right to the best healthcare available, free from discrimination according to the nature of their limitations."(10).

The findings in our study were similar to findings from Encouraging the Health of those who are disabled in sexual and reproductive matters WHO that transportation is a major issue for many persons with disabilities; some are unable to walk to clinics, community centers, or other places where SRH services are accessible (43). Additional evidence supports this study's findings regarding transportation difficulties (20,36,44). As a result, women with a disability may require mobility devices like tricycles, personal assistance services, or financial aid to access mainstream SRH programs. Again, when considering transportation systems to increase access to health services, planners will be able to broaden their perspective to address all members of the community.

From these finding some participants recommend making SRH services available to PWDs close to mosques and churches. In our country, there are a lot of disabled people who reside close to mosques and churches living in poverty and dwelling. They cannot reach health care due to many problems starting from lack of awareness, difficulty in mobility, financial difficulty, and fear of

discrimination. A participant from a physical disability noted that using a tent and having a disability corner for SRH information like blood donation campaigns even if for a month.

The findings show that participants' knowledge of reproductive health services (RHS) varies among participants. WWDs typically have insufficient knowledge and awareness of SRH, indicating that they require the utilization of SRH service information. In the study, blind women revealed the lack of Braille information on reproductive and sexual health issues. This is similar to a study finding done by Ananaba Chika Queen in Nigeria, where people with disabilities face challenges in accessing SRH services, including unavailable Braille information on sexual and reproductive health (22). Most of the participants in these studies recommend educating WWDs about SRH services, education, and awareness creation related to sexual and reproductive health as necessary to ensure the utilization of SRH services for women who are disabled.

According to this study, Social support and network structure as key elements for PWDs to have accessible SRH according to the participant's testimony. The support should include finances, mobility aid, communications, and safeguarding for WWDs. however, most women with disabilities didn't get support. as also shown in other settings including a qualitative study conducted in Senegal (39).

The study's findings revealed that education or knowledge has a significant impact on using SRH services. Educated women have an advantage over those with less education since knowledge provides much information concerning the issues. Women who are less educated are victims of a lack of awareness. This is similar to a study finding done in Bangladesh (41).

Other studies revealed that the enablers are caregivers' support and the positive attitude of health care providers when accessing treatment at the health facility (34), and the same thing in this finding too. Positive relationships with a health care provider can determine the ability to seek care and enhance SRH service access to care. some participants have acknowledged that they have a very well-built personal relationship with caregivers who eagerly support them when seeking SRH service. A participant from the blind association when she told me about her experience of antenatal care and delivery service said that I was attentive starting from the month of my pregnancy up to the nine months because a person who was conducting my follow-up was a nice person who gave me a great attention all the way.

The last emerged sub-them where women's self-confidence /assertiveness in ensuring access to SRH services. Despite numerous outside influences, some of the women's stories revealed that an internalized perception of themselves as acceptable clients is the main point to utilizing SRH services like the general women.

A participant from the blind association said that disabled people shall strive to get the information with their initiations and that we shall not wait as the world is swiftly changing from time to time. We shall not wait to get the information written in brail or prepared in sign language.

7. STRENGTHS AND LIMITATIONS

7.1. Strength

This is the first qualitative study regarding barriers and enablers to accessing SRH services among women who are disabled. One of the study's strengths was that the researcher recruited participants directly through a local disability association. This developed trust between those who participated and PI.

This study tried to give an in-depth insight into the participants by avoiding researcher bias during each interview. In these studies, data were triangulated (in-depth interview and FGD), this helped ensure the validity of the research. The interview was composed of women with different age groups, educational levels, occupational statuses, and experiences; This can give a deep insight into barriers and enablers to accessing SRH services. The result of this study shows real barriers and enablers faced by women who are disabled in accessing SRH services.

7.2. Limitation

The study only included perspectives of physically disabled and blind women without the perspectives of other types of disabilities. Since this research was qualitative, the generalizability of the results and the small number of participants are the limitations of the study.

8. CONCLUSION AND RECOMMENDATION

8.1. CONCLUSION

The finding revealed that visually impaired women and women with physical disabilities experienced several barriers in accessing SRH services and care. Starting from the negative attitudes in families and communities in which they live, structural hurdles in HFs, financial constraints, transportation issues, and lack of information regarding SRH programs. These could prevent an individual from taking the step to seek SRH service and care. Enablers are Social support and network, Access to education increases awareness of SRH services, Positive providers' attitudes, and women's self-confidence /Assertiveness in ensuring access to SRH services. To address the barriers and encourage enablers, SRH care Guidelines and programs need to take into account women with disabilities, and actions to eliminate economic barriers to service utilization and promote positive interactions with community members and healthcare providers should be implemented.

8.2. RECOMMENDATION

To Addis Ababa health bureau:

- ✓ Addis Ababa health bureau is recommended to work on creating awareness about the SRH service for the community through media outlets and making facilities accessible to them. Additionally, it would be important to mobilize the community and engage support networks to create a more receptive atmosphere for women with disabilities to talk openly about their SRH and access to SRH information and services.

- ✓ Again, the Addis Ababa health bureau needs to ensure training for health care providers including training on the sexual reproductive health rights of WWDs to ensure SRH services that are responsive to their needs and also focus on making SRH service-provider facilities more disability-friendly.

- ✓ Financial coverage is better to be introduced for women who are disabled to use free or subsidized SRH services, including ensuring access to insurance coverage.

To disability association:

- ✓ Association who work with disabilities giving training and other awareness-creation activities regarding SRH service for WWD.

To Universities:

- ✓ The university could prepare training and SRH service education related to disability. For those graduate students, linking them to a disability association that works on women with disabilities means letting them have a disability and health courses or experience sharing with women with disabilities.

To researchers:

- ✓ Further nationally representative studies are to be undertaken, considering other settings than the current setting, with a mixed study design, and it is also nice to see the SRH service among women with different disability types.

9. References

1. Roseman MJ, Reichenbach L. International conference on population and development at 15 years: Achieving sexual and reproductive health and rights for all? Am J Public Health. 2010;100(3):403–6.
2. Fathalla MF, Fathalla MMF. Sexual and Reproductive Health: Overview. Int Encycl Public Heal. 2016;(November):481–90.
3. WHO. Universal access to sexual and reproductive health: [Internet]. New tools offer strategies on integrating sexual and reproductive health into primary health care, as a fundamental component of universal health coverage. 2022. Available from: https://www.who.int/news/item/19-07-2022-universal-access-to-sexual-and-reproductive-health
4. UNICEF. Situation and access to services of a person with disabilities in Addis Ababa. Briefing note. 2021;
5. Shakespeare T, Hameed S, Kiama L. Actions, not words: progress since ICPD on disability and SRHR. Sex Reprod Heal Matters. 2019;27(1):0–2.
6. Statistics Disablity. Information, Charts, Graphs, and Tables.
7. UN Women. Making the SDGs Count for Women and Girls with Disabilities. 2007;1–5. Available from: https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2017/making-sdgs-count-for-women-with-disabilities.pdf?la=en&vs=731
8. Nosek MA, Hughes RB, Swedlund N, Taylor HB, Swank P. Self-esteem and women with disabilities. Soc Sci Med. 2003;56(8):1737–47.
9. Uyar K, Delele GM, Iseri EI. Web Accessibility of the Federal Democratic Republic of Ethiopia Governmental Websites. Int J Comput Sci Netw Secur. 2020;20(6):144–51.
10. Eide AH, Mannan H, Khogali M, Van Rooy G, Swartz L, Munthali A, et al. Perceived barriers to accessing health services among individuals with disability in four African countries. PLoS One. 2015;10(5):1–13.
11. Disabilities AW, States U, Steele CB, Townsend JS, Courtney-long EA, Young M. 2013. 2017;1–9.
12. Tracking Universal Health Coverage: 2017 Global Monitoring Report. Tracking Universal Health Coverage: 2017 Global Monitoring Report. 2017.
13. Obasi M, Manortey S, Kyei KA, Addo MK, Talboys S, Gay L, et al. Sexual and reproductive health of adolescents in schools for people with disabilities. Pan Afr Med J. 2019;33.
14. Nguyen TTA, Liamputtong P, Monfries M. Reproductive and Sexual Health of People with Physical Disabilities: A Metasynthesis. Sex Disabil. 2016;34(1):3–26.
15. disability Who report 2022 [Internet]. Available from: https://www.who.int/news-room/fact-sheets/detail/disability-and-health
16. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet. 2018;391(10140):2642–92.

17. Global report on health equity for persons with disabilities.

18. Márton S, Polk G, Fiala D. Committee on the Rights of Persons with Disabilities Views adopted by the Committee at its tenth session (2-13 September 2013). 2013;(October). Available from: https://www.refworld.org/pdfid/5280d17a4.pdf

19. Access to SRHR services for disabled women, girls, WOMEN'S ACTION GROUP, PROJECT DOCUMENT in ZIMBABWE, January 2018 - December 2018.

20. Rugoho T, Maphosa F, Programme L, Disability LC. Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe : The case of Chitungwiza town Research objectives. 2014;1–8.

21. Groce N, Kembhavi G, Wirz S, Lang R, Trani J-F, Kett M. Poverty and Disability – A Critical Review of the Literature in Low and Middle-Income Countries. SSRN Electron J. 2019;(November 2017).

22. Queen AC. THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF PEOPLE LIVING WITH DISABILITIES IN NIGERIA : Factors Influencing Access and Utilisation of Services Ananaba Chika Queen.

23. Caballero MA, Martin JP, Fernando L, Gatjens A, Schaaf M, Reenen TP Van, et al. Mauricio Albarracín Caballero. 2005;

24. Foster K, Sandel M. Abuse of women with disabilities: Toward an empowerment perspective. Sex Disabil. 2010;28(3):177–86.

25. Reproductive POF, Women HA, Disabilities W. Health Among Women With Disabilities Dhs Analytical. 2022;(June).

26. Shiwakoti R, Gurung YB, Poudel RC, Neupane S, Thapa RK, Deuja S, et al. Factors affecting utilization of sexual and reproductive health services among women with disabilities- a mixed-method cross-sectional study from Ilam district, Nepal. BMC Health Serv Res [Internet]. 2021;21(1):1–19. Available from: https://doi.org/10.1186/s12913-021-07382-4

27. Kumi-kyereme A, Coast C, Kumi-kyereme A. Sexual and reproductive health services utilization amongst in-school young people with disabilities in Ghana. 2019;1–9.

28. Mesfin Y. Disparities in Sexual and Reproductive Health Service Utilization and Associated Factors among Adolescents with and without Disability in Southern Ethiopia. 2021;2021.

29. Kassa TA, Luck T, Bekele A, Riedel-Heller SG. Sexual and reproductive health of young people with disability in Ethiopia: A study on knowledge, attitude, and practice: A cross-sectional study. Global Health [Internet]. 2016;12(1):1–11. Available from: http://dx.doi.org/10.1186/s12992-016-0142-3

30. Jote T. A review of disability inclusion for refugees in Ethiopia and recommendations for future practice. 2022;(June).

31. Nguyen A. Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review. Sex Disabil [Internet]. 2020;38(3):371–88. Available from: https://doi.org/10.1007/s11195-020-09630-7

32. Lee K, Devine A, Marco MJ, Zayas J, Gill-Atkinson L, Vaughan C. Sexual and reproductive health services for women with disability: A qualitative study with service providers in the Philippines. BMC Womens Health. 2015;15(1):1–12.

33. Seidu A. Utilisation of Sexual and Reproductive Health Services among Young People With Disabilities in Ghana ABDUL-AZIZ SEIDU. Unpublished Thesis. 2020;(July 2018).

34. Badu E, Gyamfi N, Opoku MP, Mprah WK, Edusei AK. Enablers and barriers in accessing sexual and reproductive health services among visually impaired women in the Ashanti and Brong Ahafo Regions of Ghana. Reprod Health Matters [Internet]. 2018;26(54):51–60. Available from: https://doi.org/10.1080/09688080.2018.1538849

35. FMOH. Health Sector Disability Mainstreaming Manual. 2017;(January).

36. Soule O, Sonko D. Examining access to sexual and reproductive health services and information for young women with disabilities in Senegal: a qualitative study. Sex Reprod Heal Matters. 2022;30(1).

37. Apolot RR, Ekirapa E, Waldman L, Morgan R, Aanyu C, Mutebi A, et al. Maternal and newborn health needs for women with walking disabilities; "the twists and turns": A case study in Kibuku District Uganda. Int J Equity Health. 2019;18(1):1–10.

38. Ahumuza SE, Matovu JKB, Ddamulira JB, Muhanguzi FK. Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. Reprod Health. 2014;11(1):1–9.

39. Burke E, Kébé F, Flink I, Van Reeuwijk M, May A Le. A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal. Reprod Health Matters [Internet]. 2017;25(50):43–54. Available from: https://doi.org/10.1080/09688080.2017.1329607

40. DeBeaudrap P, Mouté C, Pasquier E, Mac-Seing M, Mukangwije PU, Beninguisse G. Disability and access to sexual and reproductive health services in Cameroon: A mediation analysis of the role of socioeconomic factors. Int J Environ Res Public Health. 2019;16(3):4–10.

41. Du KC, Mohosin AB, Amin A, Hasan T. Influence of education on sexual and reproductive health service utilization for persons with disabilities in nationwide Bangladesh : an explanatory sequential mixed-methods study. Reprod Health [Internet]. 2022;1–15. Available from: https://doi.org/10.1186/s12978-022-01352-7

42. Mitra S mname. Disability, Health, and Human Development. SSRN Electronic Journal. 2018.

43. Promoting sexual and reproductive health for persons with disabilities WHO / UNFPA guidance note.

44. Mesiäislehto V, Katsui H, Sambaiga R. Disparities in accessing sexual and reproductive health services at the intersection of disability and female adolescence in Tanzania. Int J Environ Res Public Health. 2021;18(4):1–14.

10. ANNEX

Annex i: Participant Written Consent Form

Title: barriers and Enablers for Women with Disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia**.** A qualitative study

You are being asked to participate in a study that **Sewnet Tilahun [PI], an M.Sc. student** from the School of Nursing and Midwifery will be conducting. This study has been approved by the School of Nursing and Midwifery, College of Health Sciences Review Board. You must be at least 18 years old to take part in this study.

Purpose: The purpose of this qualitative study is to explore the barriers and enablers for women with disabilities to access sexual and reproductive health services in Addis Ababa, Ethiopia.

Voluntary Nature of the Study/Confidentiality:

Your participation in this study is entirely voluntary and you may refuse to complete the study at any point during the experiment, or refuse to answer any questions with which you are uncomfortable. You may also stop at any time and ask the researcher any questions you may have. All interview sessions will be recorded using a voice recorder. Your name will never be connected to your results or your responses in the Interviews [IDI or FGD]; instead, a number will be used for identification purposes. Information that would make it possible to identify you or any other participant will never be included in any report. The data will be accessible only to those working on the project. Your participation in the study has no risks. There is no direct short-term benefit for participants. However, this study will help to improve reproductive health service provision for women with a disability and it may also be used by the policymakers to evaluate the service and help them to improve it. To complete the semi-structured questionnaire guide it will take 30-60 minutes for IDI and 2-3 hours for FGD.

Contact and Questions:

At this time you may ask any questions you may have regarding this study. If you have questions later, you may contact Sewnet Tilahun **[PI]** at +251925406719 or sewnet9tilahun@gmail.com

Statement of Consent:

I have read the above information. I have asked questions about the procedure, and they have been answered to my satisfaction. I consent to participate in this study.

Name of Participant_____Date: _____
(Please print)

Signature of Participant _____

Advisors' Contact Address:

Endalew Gemechu Sendo (PHD, RN, Asst.Professor)
E-mail: endalewaau2012@gmail.com
Telephone: +251911196298
Haweni Adugna (MSC, Asst Professor)
Email: haweniia@gmail.com.
Telephone: +251911340112

Thanks for your participation!

Signature of research participant ----------

Signature of researcher ----------

Date ----------

Annex ii: an interview guide for in-depth interviews [English version]

Thank you for making time to take part in this in-depth interview. My name is _____

Personal information

- Please tell me about yourself

S.No	Response of reviewee	Remark
Age		
marital status		
your children		
Educational status		
your religion		
Occupational status		

1. **Now, let us start with your views and experiences about disabilities and sexual and reproductive, and contraception use**

- What is your opinion about sexual and reproductive among women with disability in society?
- Have you ever had a relationship with the opposite sex?
    - If so, for how long?
    - Are you currently in a relationship? If not, why?
- If you are sexually active, have you used contraception to prevent pregnancy?
    - If "yes", what kinds of contraceptive methods have you used and why?
    - If "no", why haven't you used it?

- Tell me your desire to have children and experiences with pregnancy antenatal care and childbirth [If any]

- What information did you receive at ANC Clinic from the health care providers about preparing for giving birth at health facilities?
- What is your opinion regarding delivering a baby in the health facility? Would you recommend health facility delivery to your friends? Why not? What are the barriers? What are the benefits of going for institutional delivery?
- Is there any unwanted or unplanned pregnancy before? [If any] How do you resolve it? Is there any abortion before? [If any] How do you resolve it?

1. **Now, let us discuss access to sexual and reproductive health services and information**
    - Tell us the challenges women with disability face in accessing SRH services and information in your locality.
    - Which barriers to accessing maternity care as a woman with a disability have you seen or personally encountered? [Probing questions may include the following]:
        - structural barriers within health facilities
        - Mobility problems[if physically disabled and blind]
        - financial barriers/ lack of insurance coverage,
        - long wait times in a health facility
        - transportation difficulties
        - health providers' attitude[i.e. lack of compassionate and respectful care, denial of treatment on grounds of disability]
        - Limited support [i.e. partner's or family support etc.]
        - women's limited awareness of sexual and reproductive health
        - Lack of access to comprehensive sexuality education etc.

2. **Let's now talk about the support and resources available for a woman with a disability for obtaining SRH services.**

    - What opportunities/supports exist in your community's healthcare system that would make it possible for a woman with a disability to obtain SRH services and information?

      Probing questions may include the following:

- Education
- Income
- Support network
- Health insurance coverage
- Treatment with preference
- Accessible health services etc.

3. **What do you recommend to help a woman with a disability have better access to sexual and reproductive health services and information in the future?**

Probing questions may include the following:

- training of health professionals on the needs of persons with disabilities
- design of accessible health services;
- advice on health service communication access;
- identification of strategies for inclusion;
- Provision of support to families of persons and patients with disabilities etc.

4. **Please use this opportunity to voice any concerns or ask any questions that haven't been addressed.**

Thank you very much for taking part in this study.

Annex iii: an interview guide for focus group discussion [FGD] [English version]

Thank you for making time to take part in this FGD. My name is _____

Personal information [Each participant]

- Please tell me about yourself

S.No	Response of reviewee	Remark
Age		
marital status		
your children		
Educational status		
your religion		
Occupational status		

1. **Now, let's begin by discussing your opinions and experiences concerning sexual and reproductive, disabilities, and obtaining SRH services and information.**

- How do you feel about the sexual and reproductive of women with disabilities in our society?
- Which barriers to accessing maternity care as a woman with a disability have you seen or personally encountered? [Probing questions may include the following]:

  - structural barriers within health facilities
  - Mobility problems[if physically disabled and blind]
  - financial barriers/ lack of insurance coverage,
  - long wait times in a health facility

- transportation difficulties
- health providers' attitude[i.e. lack of compassionate and respectful care, denial of treatment on grounds of disability]
- Limited support [i.e. partner's or family support etc.]
- lack of information and communication materials
- Lack of access to comprehensive sexuality education etc.

2. Let's now discuss the support and resources that a woman with a disability can use to get access to SRH services.

- What opportunities/supports exist in your community's healthcare system that would make it possible for a woman with a disability to obtain SRH services and information?

Probing questions may include the following:

- Education
- Income
- Support network
- Health insurance coverage
- Treatment with preference
- Accessible health services etc.

3. **What do you recommend to help a woman with a disability have better access to sexual and reproductive health services and information in the future?**

Probing questions may include the following:

- training of health professionals on the needs of persons with disabilities
- design of accessible health services;
- advice on health service communication access;
- identification of strategies for inclusion;
- Provision of support to families of persons and patients with disabilities etc.

4. **Please use this opportunity to voice any concerns or ask any questions that haven't been addressed.**

Thank you very much for taking part in this study.

Annex IV: consent form in Amharic

ርዕስ፡ የአካል ጉዳተኛ ሴቶች የጾታዊ እና የስነ ተዋልዶ ጤና አገልግሎቶችን እንዲያገኙ እንቅፋቶችን እና ኢጋሮችን መዳሰስ አዲስ አበባ፣ ኢትዮጵያ ።

ይህ የምርምር ጥናት በሰውነት ጥላሁን (ዋና ተመራማሪ)፣ ኤም.ኤስ.ሲ. የነርስ እና ሚድዋይፈሪ ትምህርት ቤት ተማሪ ያካሂዳል። ይህ ጥናት በነርሲንግ እና ሚድዋይፈሪ ትምህርት ቤት፣ በጤና ሳይንስ ኮሌጅ ግምገማ ቦርድ ጸድቋል። በዚህ ጥናት ውስጥ ለመሳተፍ ቢያንስ 18 አመት መሆን አለቦት።

ዓላማው፡ አካል ጉዳተኛ ሴቶች የጾታ እና የስነ ተዋልዶ ጤና አገልግሎትን እንዲያገኙ እንቅፋቶችን እና ኢጋሮችን ለመዳሰስ በአዲስ አበባ፣ ኢትዮጵያ ነው።

የጥናቱ በፈቃደኝነት ተፈጥሮ/ምስጢራዊነት፡-

በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው እና በ ጥናቱን ወቅት ጥናቱን በማንኛውም ጊዜ ለማጠናቀቅ እምቢ ማለት ወይም የማይመቹዎትን ማንኛውንም ጥያቄዎች ለመመለስ እምቢ ማለት ይችላሉ። እንዲሁም በማንኛውም ጊዜ ቆም ብለው ለተመራማሪው ማንኛውንም ጥያቄ መጠየቅ ይችላሉ። ሁሉም የቃለ መጠይቅ ክፍለ ጊዜዎች በድምጽ መቅጃ ይቀዳሉ።

የእርስዎ ስም ከውጤቶችዎ ወይም በቃለ መጠይቆች ውስጥ ካሉ ምላሾችዎ ጋር በጭራሽ አይገናኝም። በምትኩ ቁጥር ለመለያ ዓላማዎች ጥቅም ላይ ይውላል። እርስዎን ወይም ሌላ ማንኛውም ተሳታፊን ለመለየት የሚያስችል መረጃ በማንኛውም ዘገባ ውስጥ አይካተትም።

መረጃው በፕሮጀክቱ ላይ ለሚሰሩ ብቻ ተደራሽ ይሆናል. በጥናቱ ውስጥ ያለዎት ተሳትፎ ምንም አይነት አደጋ የለውም።በአሁኑ ጊዜ ጥናቱ ለመረጃ ሰጪው ቀጥተኛ ጥቅሙ ቅርብ ባይሆንም መረጃው ተሰብስቦ፤ ተቀነባብሮና ተተንትኖ ከተጠናቀቀ በኋላ ለፖሊሲ አውጪዎች እና ለጤና አገልግሎት ሰጪዎች እንደ ግብአት በመሆን ለአካል ጉዳተኛ ሴቶች በሚሰጡ የስነ-ተዋልዶ ጤና አገልግሎቶች አሰጣጥ ዙሪያ እቅዶችን ለማውጣት ይጠቅማል::መጠይቁን ሞልቶ ለማጠናቀቅ ከ30-60 ለጥልቅ ቃለ መጠይቅ እና 2-3 ሰዓት የቡድን ውይይት ሊወስድ ይችላል፡

ግንኙነት እና ጥያቄዎች፡-

በዚህ ጊዜ ይህንን ጥናት በተመለከተ ማንኛውንም ጥያቄ መጠየቅ ይችላሉ።

በኋላ ላይ ጥያቄ ካሎት ሰውነት ጥላሁን [(ዋና ተመራማሪ] በ +251925406719 ወይም sewnet9tilahun@gmail.com ማግኘት ይችላሉ።

የፍቃድ መግለጫ፡-

ከላይ ያለውን መረጃ አንብቤዋለሁ።

ስለ አሰራሩ ጥያቄዎችን ጠይቄያለው፣ በመልሱም እርካታ አግኝቸሃልዉ።

በዚህ ጥናት ለመሳተፍ ፈቃደኛ ነኝ።

የተሳታፊው ስም _____ ቀን: _____

(እባክዎ ያትሙ)

የተሳታፊ ፊርማ _____

የአማካሪዎች አድራሻ፡- Endalew Gemechu Sendo (PHD, RN, Asst.Professor)

ኢሜል፡- endalewaau2012@gmail.com

ስልክ፡+251911196298

Haweni Adugna (MSC, Asst Professor)

ኢሜል : haweniia@gmail.com

ስልክ፡ +251911340112

ለተሳትፎዎ እናመሰግናለን!

Annex V: an interview guide for in-depth interviews [Amharic version]

በዚህ ቃለ መጠይቅ ውስጥ ለመሳተፍ ጊዜ ስለሰጡን እናመሰግናለን።

ስሜ _____ ነው

የግል መረጃ

እባክሽ ስለራስሽ ንገረኝ

S.No	Response of reviewee	Remark
ዕድሜ		
የትዳር ሁኔታ		
ልጆችሽ		
የትምህርት ደረጃ		
ሃይማኖትሽ		
አሁን ያለሽ ሥራ)		

1. አሁን፣ ስለ አካል ጉዳተኝነት እና ጾታዊ እና የስነ ተዋልዶ ጤና እና የእርግዝና መከላከያ አጠቃቀም ካለሽ አመለካከት እና ልምድ እንጀምር

- በማህበረሰቡ ውስጥ ባሉ አካል ጉዳተኛ ሴቶች ላይ ስለ ጾታዊ እና የስነ ተዋልዶ ግንኙነት ምን አስተያየት አለዎት?
- ከተቃራኒ ጾታ ጋር ግንኙነት ነበራችሁ?
- ከሆነስ ለምን ያህል ጊዜ?
- በአሁኑ ጊዜ በግንኙነት ውስጥ ነዎት?
- ካልሆነ ለምን?
- የግብረ ሥጋ ግንኙነት ከፈጸሙ እርግዝናን ለመከላከል የወሊድ መከላከያ ተጠቅመዋል?
- “አዎ” ከሆነ፣ ምን ዓይነት የወሊድ መከላከያ ዘዴዎችን ተጠቅመዋል እና ለምን?
- "አይ" ከሆነ ለምን አልተጠቀምሽም?
- ልጅ የመውለድ ፍላጎትዎን እና ከእርግዝና የቅድመ ወሊድ እንክብካቤ እና ከወሊድ ጋር ያለውን ልምድ ይንገሩኝ [ካለ]

- ከእርግዝና የቅድመ ወሊድ እንክብካቤ ክሊኒክ ከጤና ባለሙያ በጤና ተቋማት ለመውለድ ስለመዘጋጀት ምን መረጃ አግኝተዋል?
- በጤና ተቋም ውስጥ ልጅ መውለድን በተመለከተ የእርስዎ አስተያየት ምንድን ነው?
- በጤና ተቋም ውስጥ ልጅ መውለድን ለጓደኞዎ ይመክራሉ?
- ለምን አይመክሩም?
- እንቅፋቶቹ ምንድን ናቸው?
- ወደ ተቋማዊ አቅርቦት መሄድ ምን ጥቅሞች አሉት?
- ከዚህ በፊት ያልተፈለገ ወይም ያልታቀደ እርግዝና ነበረሽ?“ አዎ” ከሆነ፣ እንዴት ነው የፈታሽዉ?
- ከዚህ በፊት ፅንስ ማስወረድ አለ? (ካለ) እንዴት ነው የተፈታዉ?

2. አሁን፣ ስለ ፆታዊ እና ስነ ተዋልዶ ጤና አገልግሎቶች እና መረጃ ስለማግኘት እንወያይ

- በአካባቢያችሁ ያለውን ፆታዊ እና ስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃን ለማግኘት አካል ጉዳተኛ ሴቶች የሚያጋጥሟቸውን ፈተናዎች ይንገሩን።
- የአካል ጉዳተኛ ሴት የወሊድ እንክብካቤን ለማግኘት የትኞቹ እንቅፋቶች አይተሻል ወይም በግል አጋጥሞሻል? [መመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ]
- በጤና ተቋማት ውስጥ መዋቅራዊ እንቅፋቶች
- የመንቀሳቀስ ችግሮች[አካል ጉዳተኛ ከሆኑ እና ዓይነ ስውር ከሆኑ]
- የፋይናንስ እንቅፋቶች / የኢንሹራንስ ሽፋን እጥረት,
- በጤና ተቋም ውስጥ ረጅም የጥበቃ ጊዜ
- የመጓጓዣ ችግሮች
- የጤና አቅራቢዎች አመለካከት [ማለትም. ርህራሄ እና አክብሮት ማጣት ፣ በአካል ጉዳት ምክንያት ህክምናን መከልከል]
- የተወሰነ ድጋፍ [ማለትም. የአጋር ወይም የቤተሰብ ድጋፍ ወዘተ.]
- ስለ ወሲባዊ እና የስነ ተዋልዶ ጤና የሴቶች ግንዛቤ ውስን ነው።

3. አሁን ለአካል ጉዳተኛ ሴት ፆታዊ እና ስነ ተዋልዶ ጤና አገልግሎቶችን ለማግኘት ስላላት ድጋፍ እና ግብአት እንነጋገር። የአካል ጉዳተኛ ሴት የፆታዊ እና ስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃዎችን እንድታገኝ የሚያስችላት በማህበረሰብህ የጤና አጠባበቅ ሥርዓት ውስጥ ምን እድሎች/ድጋፎች አሉ?

የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ፡-

- የትምህርት ደረጃ
- የገቢ ምንጭ
- የጤና ኢንሹራንስ ሽፋን

- ከምርጫ ጋር የሚደረግ ሕክምና
- ተደራሽ የጤና አገልግሎት ወዘተ.

5. አካል ጉዳተኛ የሆነች ሴት የፆታዊ እና የስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃዎችን ወደፊት በተሻለ መንገድ እንድታገኝ ለመርዳት ምን ትመክራለሽ?

የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ፡-

- በአካል ጉዳተኞች ፍላጎቶች ላይ የጤና ባለሙያዎች ስልጠና
- ተደራሽ የጤና አገልግሎቶች ንድፍ;
- በጤና አገልግሎት የግንኙነት ተደራሽነት ላይ ምክር; የማካተት ስልቶችን መለየት;
- ለአካል ጉዳተኞች ቤተሰቦች እና ታካሚዎች ድጋፍ መስጠት, ወዘተ.

6. እባካችሽ ይህንን እድል ተጠቅማችሽ ስጋቶችን ለመግለፅ ወይም ምላሽ ያልተገኘለትን ማንኛውንም ጥያቄ ጠይቁ።

በዚህ ጥናት ላይ ስለተሳተፉ በጣም እናመሰግናለን።

Annex VI: an interview guide for focus group discussion [FGD] [Amharic version]

በዚህ የቡድን ውይይት ውስጥ ለመሳተፍ ጊዜ ስለሰጡን እናመሰግናለን።

ስሜ _____ ነው

የግል መረጃ [እያንዳንዱ ተሳታፊ]

እባክሽ ስለራስሽ ንገሪኝ

S.No	Response of reviewee	Remark
ዕድሜ		
የትዳር ሁኔታ		
ልጆችሽ		
የትምህርት ደረጃ		
ሃይማኖትሽ		
አሁን ያለሽ ሥራ)		

1. አሁን፣ ስለ ጾታዊነት፣ አካል ጉዳተኝነት፣ እና የፆታዊ እና የስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃዎችን በማግኘት የእርስዎን አስተያየት እና ተሞክሮ በመወያየት እንጀምር።

- በህብረተሰባችን ውስጥ ስለ አካል ጉዳተኛ ሴቶች ጾታዊ እና የስነ ተዋልዶ ምን ይሰማዎታል?
- እንደ አካል ጉዳተኛ ሴት የወሊድ እንክብካቤን ለማግኘት የትኞቹ እንቅፋቶች አይተሃቸው ወይም በግል አጋጥሟቸዋል?

[መመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ]

- በጤና ተቋማት ውስጥ መዋቅራዊ እንቅፋቶች
- የመንቀሳቀስ ችግሮች[አካል ጉዳተኛ ከሆኑ እና ዓይነ ስውር ከሆኑ]
- የፋይናንስ እንቅፋቶች / የኢንሹራንስ ሽፋን እጥረት,
- በጤና ተቋም ውስጥ ረጅም የጥበቃ ጊዜ
- የመጓጓዣ ችግሮች
- የጤና አቅራቢዎች አመለካከት [ማለትም. ርህራሄ እና አክብሮት ማጣት ፣ በአካል ጉዳት ምክንያት ህክምናን መከልከል]

- የተወሰነ ድጋፍ [ማለትም የአጋር ወይም የቤተሰብ ድጋፍ ወዘተ.]
- የመረጃ እና የመገናኛ ቁሳቁሶች እጥረት

2. አሁን የአካል ጉዳተኛ ሴት የፆታዊ እና የስነ ተዋልዶ ጤና አገልግሎቶችን ለማግኘት የምትጠቀምባቸውን ድጋፎች እና ግብዓቶች እንወያይ።

የአካል ጉዳተኛ ሴት የፆታዊ እና የስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃዎችን እንድታገኝ የሚያስችላት በማህበረሰብህ የጤና አጠባበቅ ሥርዓት ውስጥ ምን እድሎች/ድጋፎች አሉ?

የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ፡-

- የትምህርት ደረጃ
- የገቢ ምንጭ
- የጤና ኢንሹራንስ ሽፋን
- ከምርጫ ጋር የሚደረግ ሕክምና
- ተደራሽ የጤና አገልግሎት ወዘተ.

3. አካል ጉዳተኛ የሆነች ሴት የፆታዊእና የስነ ተዋልዶ ጤና አገልግሎቶችን እና መረጃዎችን ወደፊት በተሻለ መንገድ እንድታገኝ ለመርዳት ምን ትመክራለህ?

የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትቱ ይችላሉ፡-

- በአካል ጉዳተኞች ፍላጎቶች ላይ የጤና ባለሙያዎች ስልጠና
- ተደራሽ የጤና አገልግሎቶች ንድፍ;
- በጤና አገልግሎት የግንኙነት ተደራሽነት ላይ ምክር;

የማካተት ስልቶችን መለየት;

ለአካል ጉዳተኞች ቤተሰቦች እና ታካሚዎች ድጋፍ መስጠት, ወዘተ.

4. እባካችሁ ይህንን እድል ተጠቅማችሁ ስጋቶችን ለመግለፅ ወይም ምላሽ ያልተገኘለትን ማንኛውንም ጥያቄ ጠይቁ።

በዚህ ጥናት ላይ ስለተሳተፉ በጣም እናመሰግናለን።

Annex VII: Themes, sub-themes, and codes with their description

Themes	Sub themes	code	Code description
Barriers of women with disabilities to access SRH services	Family/Community negative attitudes	Lack of awareness	They think SRH service is not necessary for disabled women.
		Perceive disability as a curse	Disability is considered as a curse in community and disabled person is considered as a sinner.
		Perceive disability as inability	They think Women with disabilities cannot do anything like sexual act and marriage.
	Structural barriers in HFs	Upstairs are not suitable	Most of the health facilities buildings were built with upstairs, these are not suitable for women with physical disabilities
		Beds are not comfortable	Health facility lacked beds that were appropriate for women with disability.
		Un functional elevators	elevators mostly did not work
	Financial barriers	Expensive cost for the service	Expenses are high to get medicines,lab,ultrasound
		can't afford the service	Cost are expensive to accesses SRH Service
		transportation cost	Unable to pay for themselves and assistant who helped them to reach the facility.
	Transportation problem	unsuitable transport	Most transporting vehicles are not suitable for disabled women for example most of the bus unable to use ramps
		Roads are difficult	There is Gurgaon, ditch which is not suitable for disabled women
		transportation expenses	The cost of transportation is high for disabled women who are unemployed
	Access to information about SRH services	Lack of information written in brail	There is no way that they could access the information since there is lack of aid (brail) that assist them.
		didn't have the room to get information	There is no situation that deal with SRH service issue because most of community(family, health care provider) believed not necessary for them

Enablers of women with disabilities to access SRH services	Social support and network	Supportive family	There is family support during utilization of SRH service
		Supportive friends	There is friends support during utilization of SRH service
		Being Members of the association	Being the member of the association helped them to access the information and get the SRH service.
	Access to education increases awareness of SRH services	Being educated	knowledge provides much information concerning the issues
		education is information	knowing has a great impact to utilize SRH service
	Positive providers' attitudes	staff was helpful	Previous positive experience in the facility enhance them to use SRH service
		staff was supportive	the health care provider Encourage them to use SRH services
		Compassionate care providers	Health care providers has empathy and give special attention to the women
	women's self-confidence /Assertiveness	ability to do SRH service	Perception of themselves as acceptable clients enhance SRH care.
		disabilities should enjoy SRH services	Utilizing SRH services like the general women.
	Health insurance coverage for PWD	better to become beneficiary of health insurance coverage	Insurance coverage could cut the price that disabled individuals are expected to pay for SRH services
		health insurance coverage is very essential	Insurance coverage could cut the price that disabled individuals are expected to pay for SRH services
	Provide training for Healthcare provider on SRH services for PWDs	Train health care	Training and awareness must be given to the health community on what is disability, the types of disability, and how to interact with women who are disabled.

		Awareness given	Training and awareness must be given to the health community on what is disability, the types of disability, and how to interact with women who are disabled.
	SRH education for PWD to promote awareness of SRH services	Availing SRH education	Availing SRH education to promote awareness.
		awareness	Availing SRH education to promote awareness
	Address disability in national SRH policy, laws, and budgets.	government should work on SRH services	women with disabilities, in national policies, laws, and budgets address or include disability
		initiation from the government to address the problem	Government work on policies, proclamations, international laws, and working collaborate with health care givers and empowering women with
	Provide PWDs with access to SRH services near mosques and churches.	Availing SRH service for people living in dwelling	reproductive health services be made available to PWDs who are poor and live near mosques and churches
		Availing SRH service for people living in poverty	reproductive health services be made available to PWDs who are poor and live near mosques and churches