Assessment of Barriers of Accessing Primary Health Care Services
For Persons with Hearing, Visual and Physical Impairments
in Gulele Sub City of Addis Ababa

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ASSESSMENT OF BARRIERS OF ACCESSING PRIMARY HEALTH CARE SERVICES FOR PERSONS WITH HEARING, VISUAL AND PHYSICAL IMPAIRMENTS IN GULELE SUB CITY OF ADDIS ABABA

BY

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Advisor	Signature	Date
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Declaration

This thesis is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been dully acknowledged.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
DFID	Department for International Development
ECDD	Ethiopian Center for Disability and Development
ENAB	Ethiopian National Association of the Blind
ENAD	Ethiopian National Association of the Deaf
ENAPHD	Ethiopian National Association of Physically Disabled
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
GO	Government Organization
HCAB	Health Care Access Barriers Model
HIV	Human Immune Virus
ICF	International Classification of Functioning
ILO	International Labor Organization
IoM	Institute of Medicine
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NGO	Non Governmental Organization
NRH-CHDR	National Rehabilitation Hospital Center for Health and Disability Research
PwD	Persons with Disabilities
UDHR	Universal Declaration of Human Rights
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Economic, Social and Cultural Organization
UNICEF	United Nations Children’s Fund
UN	United Nations
WB	World Bank
WHO	World Health Organization

Abstract

People with disabilities are entitled to using health facilities at least as much as the general population if not more. Inadequate health services coupled with the absence of a disability-friendly health care system and social environment in the developing nations make it difficult for persons with disabilities to access basic medical services. The study uses a qualitative research methodology to describe and understand barriers to access health services for persons with visual, hearing and physical disabilities. The study is conducted in Gulele Sub City of Addis Ababa. I found out that there are barriers related to the physical environment, inaccessibility of transportation and health information. The knowledge and attitude of health care providers is also identified as a barrier and poverty as a facilitating factor behind the barriers. Communication with providers was also an issue when it comes to individuals with hearing impairments because they found it hard to communicate their health conditions to providers if they did not have interpreters of their own. Study records that rising to the challenge of providing excellent and accessible health care to persons with impairments is imperative as a matter of equity and recommends health professionals, health administrators and all other concerned to work hard in realizing the rights of this population and avoid the misconceptions on disability and make all services barrier free for persons with disabilities to the greatest extent possible.

Keywords: Barriers, Health services, Persons with disabilities, Access

Chapter One

Introduction

1.1 Background of the Study

Persons with Disabilities (PwDs) have been considered negatively; victimized by segregation, marginalized treatment in every aspect of life including education, health and family life; often removed from normal social life. This is due to prejudices that see disability as an illness and society can help them by extending charity. With the evolution of disability and society, this attitude has been modified towards social and human rights-based approaches that see disability as a social construct and that PwDs undergo the limitations created by society (Aytenew, 2012).

The International Community recognized the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms and for all these to happen the international convention for the rights of persons with disabilities was adopted in 2006 after long debates.

The contribution of a health system to improving health depends, firstly, on how easily a person can access appropriate and effective health services in case of medical need. Access to effective preventive and curative interventions is one of the two components of universal coverage, while the other is protection against financial hardship as a result of using services.

The ability to use services when they are needed is associated with factors related to both service provision and service usage - i.e. to supply and demand factors. On the provision side, there has to be an adequate supply of quality services that are efficacious. To what extent a person uses the services depends on many factors. Firstly, people have different expectations of their health and therefore have different perceptions of their health care needs. When need is perceived, many other factors still govern the actual use of services. Financial affordability, in terms of the costs of the services as well as the costs of accessing them is important. However, many non-financial reasons may also be important, such as physical accessibility and cultural acceptability of the services and various forms of social exclusion and marginalization (World Health Organization, 2010).

The human right to health care is clearly linked to the rights to life and non-political freedom. Health care is either life-preserving or serves to alleviate or eliminate sickness or suffering which are barriers to our ability to develop fully as human beings.

Access to health care is a crucial element of any health care delivery system because the opportunity to obtain health care exists if there is availability and adequate supply of services. Measuring and facilitating access to health care therefore contributes to a greater understanding of the performance of health systems within, and between countries. After the launching of the Bamako Initiative in 1988, many African countries have adapted "comprehensive primary health care programmes" to solve the health problems of their citizens. Furthermore, the United Nations proclaimed Millennium Development Goals of 2000 targets improved health care for all (United Nations, 2002). Factors that hamper easy access to health care in Africa include geographical, economic, attitude of health workers toward patients, administrative and socio-cultural (Eng et al., 1998; Blustein and Weitzman, 1995; Baker et al., 1996).

Access refers to people's ability to obtain and appropriately use good quality health technologies when they are needed. Access is not only a technical issue involving the logistics of transporting a technology from the manufacturer to the end-user. Access also involves social values, economic interests, and political processes. Access requires a product as well as services and is linked to how health systems perform in practice. We think of access not as a single event but as a process many activities and actors over time. Access is not a yes-or-no dichotomous condition, but rather a continuous condition of different degrees; more like a rheostat than an on-off switch (Laura J. & Michael R., 2008).

The social model of disability acknowledges that obstacles to participation in society and its institutions reside in the environment rather than in the individual and that such barriers can and must be prevented, reduced or eliminated. Environmental obstacles come in many guises and are found at all levels of society. They are reflected in policies and regulations created by governments. Such obstacles may be physical – for example barriers in public buildings, transportation and recreational facilities. They may also be attitudinal – wide spread underestimation of the abilities and potential of children with disabilities creates a vicious cycle of under expectation, under-achievement and low priority in the allocation of resources (UNICEF, 2007).

The socio-economic statuses (being poor, uneducated, stigmatized and marginalized) of persons with disabilities within society present a unique challenge for them to access basic social services including health services and related messages. The existing negative values and misconceptions towards persons with disabilities have excluded them from the mainstream of society and provision of public services and special programs. This has resulted in making people with disabilities one of the poorest of the poor population in the nation (Tirusew , 2005; Kassahun , 2005).

Perhaps the greatest barrier to mainstreaming disability however is stigma and prejudice. Long established negative beliefs about what causes of disability and the limitations of persons with disabilities, are often firmly held and difficult to dispel, even among those who work in international development or health circles. Such stigma frequently means that non disabled members of the community are reluctant to participate in the same development programs as persons with disabilities (Murphy, 1987).

1. 2 Statement of the Problem

In 1993, the Ethiopian health policy declared equitable, acceptable and accessible health services to all who need them. In order to implement the declaration directly, the government is engaged in constructing more health institutions in order to improve physical accessibility and other related health service provision challenges. But, from the fact that there is no equitability between demand and availability of medical services and health personnel in different parts of country, no clear basis on the decision of planning and distribution of health care facilities over the years (Asmerom, 1994).

Persons with disabilities face barriers in their participation as equal members of society in all parts of the world. Especially in the developing world such as Ethiopia, the severity of barriers persons with disabilities face have rendered them largely excluded from the mainstream society and experience severe difficulties in accessing community resources. This segment of the society continues to face numerous barriers despite decades have elapsed since the international community has recognized the problem and adopted various instruments towards advancing their status.

Persons with disabilities experience great disparities to access health care than the rest of the population. A report by Pamies et al. (2011) pointed out that “Aside from the public health issues that most racial/ethnic minorities face, minorities with disabilities experience additional disparities in health, prejudice, discrimination, economic barriers, and difficulties accessing care as a result of their disability—in effect, they face a “double burden.” (cited in Yee, 2011).

People with disabilities face numerous barriers in realizing equal opportunities; environmental and access barriers, legal and institutional barriers, and attitudinal barriers which cause social exclusion. Social exclusion is often the hardest barrier to overcome, and is usually associated with feelings of shame, fear and rejection. Negative stereotypes are commonly attached to disability. People with disabilities are often assigned a low social status and in some cases are considered worthless which make them excluded not to get basic services (DFID, 2000).

Article 41(5) of the FDRE constitution obliges "The State within available means to allocate resources to provide rehabilitation and assistance to the physically and mentally disabled". Similarly, Article 25 of the United Nations Convention on Persons with Disabilities (UNCRPD) made obligatory for state parties to "Take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation with the same range, quality and standard of free or affordable health care and programs as provided to other persons to minimize and prevent further disabilities" (United Nations, 2006). Nevertheless, with the presence of the above legal documents, persons with disabilities are facing challenges to access health care.

Because of such simple reasons like: lack of access to building or transportation, or the inability to communicate orally for the hearing and speech impaired and in writing for the visually impaired, PwDs are often excluded from society's activities and prevented from participating in using public services (ILO, 1998: 29). This research explored the barriers to access health care services by persons with disabilities so that this vulnerable section of the society will be mainstreamed in the provision of health services.

1.3 Research Questions

The thesis will address the following research questions:

1. What are the major barriers of accessing primary health care services for persons with visual, hearing and physical impairments?

2. What are the perceptions of service users and service providers on the barriers of accessing health care services?

3. What are the consequences of the barriers on the lives of persons with disabilities?

4. How persons with disabilities cope with the barriers of accessing health care services?

1.4 Significance of the Study

Persons with disabilities are one of the social categories that are usually neglected in disease prevention, management and care. Many health programs and projects do not target the disabled persons. However, it is evident that the disabled like other groups are also at the risk of contracting diseases and therefore should be targeted (Groce, N., & Trasi R., 2004).

Involving the disabled adds value to the programs, as they not only become beneficiaries but also participants. There are very few studies conducted on health and disability in Ethiopia. Those very few are done on HIV and reproductive health needs of persons with disabilities. This research is the first of its kind by focusing on the barriers of accessing health care services for persons with disabilities so that it will build the knowledge gap and policy makers and practitioners will give priority to the needs of this vulnerable section of the population.

1.5 Objectives of the Study

General objective

The general objective of this research is to assess the barriers of accessing health services and the experiences and coping mechanisms for persons with visual, hearing and physical impairments.

Specific objectives

- To identify the main barriers of accessing health care services for persons with disabilities.
- To explore the perceptions of service users and service providers on the barriers of accessing health care services
- To explore how persons with disabilities experience the barriers of accessing health services

- To identify the coping mechanisms of persons with disabilities while facing the health care access barriers.

1.6 Limitation of the Study

Resources and time are the very limitations of this study. Because of this, the research does not include persons with disabilities out of Gulele Sub City of Addis Ababa. The research is also limited to only persons with visual, hearing and physical impairments. The data collected from persons with hearing impairments was via a sign language interpreter which impacted free discussion with interviewees since the researcher could not communicate with sign language.

1.7 Definition of Terms

Access: Although there is no universally accepted definition of access to health services (Oliver and Mossialos, 2004), we use the definition by Peters et al. (2008) which implies 'the timely use of service according to need'.

Barrier: For this research, a barrier is any obstacle or hindrance that impedes the use of health services by persons with disabilities.

Deaf (Hard of Hearing): Deafness is having difficulty in hearing sound. Hearing loss may be mild, severe or profound. Children may bear with poor or no hearing. Most elderly people miss some hearing with their age. Hearing impairment is a full or partial decrease in the ability to detect or understand sounds caused by a wide range of biological and environmental factors, loss of hearing can happen to any organism that perceives sound (Beckles, 2004).

Disability: Definition of disability often depends on the national social legislation and cultural standards. This makes the concept difficult to understand in global context.For the purpose of this study the UN General Assembly's (1993) definition of disability as **"**a permanent physical or mental impairment that limits one or more major life activities. People are said to have disability if they find it difficult to move, see, hear, feel, think, control them or do certain things" is used.

Impairment: There is no one definition for the term impairment. Jonson (1993:2) describes impairment as a disease caused by defective genes or injuries during or after birth, which often leads to disability. Impairment could also be 'permanent or transitory in nature' (UN, 1994:9). However, for the purpose of this research, impairment refers to "physical or mental disease, loss, abnormality or injury. It includes lack of part or all limbs; partial or total defects of eyes, ears; brain damage and failure to develop to maturity in any organ or body mechanism (Daniel, 2000:7).

Persons with Disabilities: The use of these terminologies varies in different cultural and social background. However, they were used interchangeably in this paper for convenience. Thus, for the purpose of this study persons with disabilities include the blind, the deaf and the physically disabled.

Physical Disability: For the purpose of this study, physical disability refers to the damage to muscle nerves, skin bones or other body parts. This could be congenital (from birth) or accidental due to injury (Malindwa, 2003).

Poverty: poverty is a multi-dimensional concept and thus no single way to define it concretely. However, for the purpose of this research focus is given to the 'basic needs approach' to define poverty. Therefore, according to Hagenaars and Vos (1988), poverty "encompasses different dimensions of deprivation that relate to human capabilities including consumption and food security, health, education, rights, voice, security, dignity and decent work."

Primary Health Care: For the purpose of this research, Primary Health Care is the first level of contact with our health system which is universally accessible to people in community and involves community participation. It covers health improvement and preventive services, such as health education and counseling, disease prevention and screening first-level services for certain conditions such as maternity, family planning and sexual health services, and dentistry (WHO, 2010)

Vulnerability: It is a complex and contested concept with a variety of definitions arising from different disciplines. It could be analyzed in different settings like poverty; health problems like HIV/AIDS and others related problems. In relation to this study, however, it encompasses the social, economic and physical factors which could increase the susceptibility of an individual or group (persons with disability) to barriers of accessing health care.

Chapter Two

Literature Review

2.1 Introduction

The 2004 World Health Organization (WHO) statistics and International Labor Organization (ILO) estimates show that about 10% of the world's populations have some forms of disabilities. Not surprisingly, 80% of these live in developing countries, including Africa where the estimate for Persons with Disabilities (PWDs) stands well over 60 million people. Following similar statistical estimate, about 7.7 million persons are with disabilities out of the total population of 80 million in Ethiopia.

The major types of observed disability, in terms of their prevalence rates are: leg impairment (23.3%), partial blindness (20.4%), total blindness (11.9%), hearing impairment (13.3%), intellectual disability (6.9%), and hearing and speaking impairments (5.9%) (WHO,2005, ILO,2004 and Wa'el Int, 2000). In addition, a study conducted by World Vision United Kingdom has clearly revealed that the underlying causes of disabilities in Ethiopia are poverty, ignorance, war, disease, harmful traditional practices and drought. On top of this, inadequate nutrition, limited access to health care and absence of educational services add fuel to the problems of individuals with disabilities in Ethiopia (DFID, 2000). According to Elwan A. (1999), PWDs in general are among the most stigmatized, poorest, and least educated of all the world's citizens.

The Universal Declaration of Human Rights (UDHR) of 1948 in its Article 25 (1) states that "Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond control"(UN, 1948).

In the United States of America, people with disabilities presently constitute one of the most disadvantaged minority groups in society and regularly encounter discrimination in critical areas of their lives, such as health care (Hwang et al, 2009). In Bangladesh, social and cultural barriers prevent certain groups including those with physical impairments from accessing health care (Hosain & Chaterjee, 1998).

2.2 Understanding Disability

Persons with disabilities are identified in the new Convention on the Rights of PwDs as "those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others". Similarly, WHO defines disability as **"**any restriction or lack (resulting from any impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". It also defines disability as a contextual variable, dynamic over time and in relation to circumstances. One is more or less disabled based on the interaction between the person and the individual, institutional and social environments (WHO/ICF, 2001).

Disability has been viewed and defined in various ways by different scholars, disciplines and organizations. Summary of different disability models are presented in the paragraphs below.

A model, in this study, is a description of a thought. The following are some models of disability explained in brief: the charity model, the medical model, the social model, and the right-based model.

According to the **Traditional model**, people with physical, sensory or mental impairments were thought of as under the spell of witchcraft, possessed by demons, or as penitent sinners, being punished by God for wrong-doing by themselves or their parents.

The **charity model** considers people with disabilities as victims of their impairments and they need special services, which they should receive in special institutions (PANE, 2010).

In the **medical model**, the issue of disability is limited to the individual. This perception of disability is merely in terms of physical, sensory or intellectual limitations. According to this model, efforts should focus on changing the individual person with disability rather than changing the society or the environment surrounding the individual (ADD, 2005; PANE, 2010).

The **social model** emphasizes that PwDs are disadvantaged because of the limitations imposed on them by social, cultural, economic, attitudinal, and environmental barriers (like the effects of inaccessible physical environment for wheelchair users) instead of their impairments. It therefore advocates for the removal of those barriers (ADD, 2005; PANE, 2010).

The **rights-based model** states that PwDs often lack denial of basic human rights such as the right to access health services, the right to education and employment, etc. Hence, laws and policies should pave ways to avoid such barriers created by society; the rationale behind is not a question of humanity or charity, it is rather a basic human right (PANE, 2010).

The human right model is a distinct sub-group, one that is inextricably linked with the social model. The human rights model, however, maintains that, regardless of their structural loss or functional limitation, PWDs are fully entitled to equal access to existing services, opportunities, and meaningful participation in activities of collective interest (ODI, 2002). Although the human right model lies on the principle of viewing persons with disability as equal citizen as others without disability (UN, 1993), the process of abiding to the rule and implementing in this context seems to be gradual and uneven across nations of the globe. The human right model considers disability as a human right issue that should be respected and valued (UN, 2006).

Aytenew (2013) in his study of the rights of persons with disabilities found out that the more society embraces people's different characteristics and develops their abilities the more it is able to remove barriers, obstacles and prejudices. The human rights-based approach is thus a response to the lack of equal opportunities and the unjustified differential treatments, which have been continually causing violations of human rights. Disability rights as human rights have finally come after series of advocacy by various human right activists, family members etc. It has been submitted that the bitter experiences of discrimination has unified PwDs to fight for disability rights to be recognized as human rights.

As discussed in the report (PANE, 2010) the two models (i.e. the social and the rights-based models) lay the foundation for the concept 'inclusive development' which aims to create an inclusive society based on the values of equality and non-discrimination through development, there by promoting human rights for all people.

2.3 Access to Health Care Services

Aday's (1975) study (as, cited in Scheer et al, 2003) defined access as the use of services relative to the actual need for care; lack of access occurs when there is need for services but those services are not utilized. According to Loue (1998):

> In the early 1970s there were several schools of thought in health services research. One group of researchers viewed access according to characteristics of the population such as family income, insurance coverage and attitudes towards the health care system. A second group depicted access as characteristics of the delivery system or system-specific attributes. Yet a third group viewed access as a consumer's experience with the health care system, which included utilization of services, and satisfaction with the organization and delivery of health care (Loue ,1998:102).

According to Millman (1993), because of difficulties in defining and measuring the concept of access, people equate access with insurance coverage or with having sufficient doctors and hospitals in the area in which they live, but having insurance or nearby health care providers is no guarantee that people who need services will get them. He, therefore, defined access as the timely use of personal health services to achieve the best possible health outcome. This is very important to consider when it comes to developing countries because most of the time clinics are built, nurses are provided, free treatment is given but the needs of those with impairments are left out, leaving a very wide gap between access, satisfaction and barrier-free community.

Freeborn & Greenlick's (1973) study (as cited in Loue, 1998) found that in the early years of investigating access, researchers assumed that accessible care was care that was available whenever the patient was in need, that the point of entry into the health care system was well defined, and that individuals used services according to their need for care. Smith, Murray, Yousafzai and Kasonka (2004) revealed that factors defining access can be captured by the three dimensions of availability, affordability, and acceptability.

The availability of health care captures all factors that relate to the actual existence of a specific service within reach of the client as well as aspects of user-friendliness, e.g. the existence of appointment systems and the convenience of opening hours. The distance to a facility is one of the indicators of access under this dimension that are easily measured.

Affordability refers to the direct and indirect costs of care relative to the client's ability to pay. Health care financing arrangements strongly affect the affordability dimension.

Lastly, acceptability covers many of the subjective, social, and cultural factors, such as the degree to which a certain service is culturally secure. For access to be non-discriminatory, health care needs should be treated similarly, without regard to the patient's age, gender, race, religion, national origin, education, place of residency, sexual orientation, ability to pay, or presumed social worth (Priester,1992).

Thiede (2005) argued that health services need to be such that they are not only medically secure but also culturally secure, i.e. they do not just fulfill the proper criteria of medical quality but they also incorporate expectations towards the health system that people have on the grounds of their culture. Access to health products and services depends on many factors. One key factor is the successful innovation of new technologies, either as new drugs, vaccines, treatment services, or as adaptations of existing products to the contexts and frameworks of low and middle income countries (Krattiger, 2007). Disability advocates point out that technology is often created without regard to people with impairments, creating unnecessary barriers to millions of people.

According to Salinas (2007) in order to achieve desired outcomes in health care, not only is careful use of technologies that are applied by health professionals is critical but also there is need for an accountable decision-making process leading to the prescription of a particular procedure for a particular process. This decision-making process, to be considered a high quality one, needs timely access to adequate appropriate information on the safety, efficacy and effectiveness of the whole menu of technologies that are available to be prescribed for different conditions to different people.

Expanding health system capacity, expressed as availability of staff, infrastructure and pharmaceuticals, is often seen as a critical element of improving outcomes in resource-poor settings. In Bangladesh, a national program was initiated to create a network of community clinics that would be easily accessible to those living in rural areas. Clinics would offer family planning, preventative services, and limited curative care to a population of 6,000, while incorporating previously outreach-based services such as contraception and immunization (Normand et al, 2002). Outreach services were especially successful in the past, possibly due to social norms discouraging women from leaving their homes. Yet studies found that when seeking care, women would bypass the new local clinics, most of which were not functioning properly due to lack of personnel and operating funds. Instead, women traveled to sub-district health centers, which were perceived to deliver better quality services. Evaluation suggested that investments may have been better spent on strengthening the already underused low-to-middle level facilities, rather than building increased numbers of dysfunctional low level facilities (Normand et al., 2002).

Research in Russia has shown that even where there is extensive infrastructure and it is widely used, it may fail to achieve good health outcomes (Parkhurst, Danichevski, and Balabanova, 2005). This is because marginalized groups, who are in most need, face systemic barriers to access and services may not be responsive to their needs (Dimitrova et al., 2006).

A further issue arises when the care being provided is ineffective. In Russia some treatments are contrary to available evidence on effectiveness and, at best, unlikely to be beneficial while, at worst, likely to be positively harmful. Examples include the almost universal hospitalization of pregnant women (Danishevski et al., 2006), the substitution of abortion for contraception (Zhirova et al., 2004), and the widespread use of inappropriate medication. This is compounded by administrative pressure to retain capacity and maintain clinical activity despite falls in funding, leading to inadequate quality of care. (Dimitrova et al., 2006)

The former communist countries of Europe also illustrate why availability of staff and facilities is insufficient to guarantee access to care as a shortage of operating funds has led to extensive out-of-pocket payments by users (Lewis, 2002).

The expansion of physical access to essential health care is accepted as a key policy objective in many middle and low-income countries but it is implicit that this access should be to ‘good quality care’. Yet, many widely used indicators, for example in the field of maternal care, in reality focus on quantity rather than on quality or appropriate use of services (Parkhurst ,Danichevski, and Balabanova, 2005).

2.4 Vulnerability of Persons with Disabilities to Barriers of Accessing Health Services

Research by Tekalign (2007) indicates that two major factors have been found to contribute to their vulnerability to diseases. First, people with disability have poor access to resources. This inaccessibility to resources is related to the prevailing poverty factors affecting the disabled. They are among the unemployed and illiterate in a society. This is because disabled children are not often sent to schools and thereby are forced into adult unemployment.

The findings of a study by Ethiopian Center for Disability and Development (2011) on sexual and reproductive health products & services use by persons with disabilities indicate that most of the reproductive health problems among PwDs are double faced. On one face, PwDs equally confront with reproductive health problems faced by people without disability. On another flip there are unique reproductive health problems faced by PwDs. The later are associated with societal stigma and discrimination towards PwDs and unfriendliness of the existing health system and health providers for PwDs. This calls for multifaceted and coordinated response from the supply side while working on increasing the reproductive health service seeking behavior of PWDs.

Research by the UK Department for International Development indicates that poverty and disability are much linked to each other. They usually reinforce each other and worsen the life of disabled people. It was argued that disabled persons’ living situation affects their chances of working, enjoying their family life and daily activities. Only 2 % of disabled persons living in developing countries have probability to access basic services and rehabilitation (DFID, 2000).

In arguing the relationship between poverty and disability Elwan (1999) discusses how poverty causes impairment as: "Poor nutrition, limited access to vaccination programs to health and maternity care, poor hygiene, bad sanitation, inadequate information about the causes of impairments, all cause disability."

Lack of health care and access to medical facilities seem to exacerbate the situations that are nothing but legacies of poverty. As a result, more and more people are being impaired because of poverty. Again because of their impairments people with disability might be forced to lead their lives in poverty. This seems the reason that compels Neufeldt (1998) to say, "A very high proportion of persons with disabilities, as compared to others, live their lives in poverty in most countries of the world." According to O'Toole and McConkey (1995), "Disability and poverty are almost synonymous the world-over although the welfare-benefit systems of the rich countries protect their disabled citizens from hunger and homelessness." Poverty is rampant among people with disabilities, given their lack of access to education and other important urban provisions. As O'Toole and McConkey's observation illustrates the situation is especially tense in developing countries since there is no support of any kind and people with disabilities are left on their own.

Gender inequality together with wide spread illiteracy and harmful traditional practices play critical role in negatively influencing health or obstetric care seeking behavior of individuals or households. This is more complicated in case of PwDs since access to basic social services such as health care and education are unacceptably poor. Literacy rates for disabled individuals are exceptionally low and they are generally denied of employment opportunity and social equality. Moreover, the stigma and discrimination associated with their disability hinders them from taking part in social, legal, religious and political affairs (Cambridge P., 1997).

People with disabilities also make special types of demands on the health-care system, as their health needs tend to be more complex and ongoing than those of the general population. Post acute and maintenance services are often crucially important to prevent functional decline and secondary health problems in this population, yet these types of care can be challenging to obtain in the American health-care system, as it is based to a great extent on an “acute-care model” (DeJong & Frieden, 2002).

In terms of socio-economic status, individuals with disabilities are less likely to be able to work, more likely to have low household incomes, and more likely to be dependent on federal and state-funded health insurance programs such as Medicare and Medicaid than those without disabilities (De- Jong et al., 2002).Although they are somewhat less likely to be uninsured than the general population (DeJong et al., 2002), they continue to experience significant gaps in coverage that cause them to delay or forgo needed care. People with disabilities tend to be in poorer health and have greater medical vulnerability and a higher prevalence of secondary conditions than the general population (Kinne, Patrick, & Doyle, 2004). Nevertheless, they tend to underutilize basic preventive services and frequently use high-cost services such as emergency room care, in part due to worsening health problems resulting from unmet medical needs (Coughlin et al., 2002).

Lack of consistent health-care access has been associated with a higher risk of secondary conditions, especially for people with more severe disabilities ((NRH-CHDR, 2002). Because of their “Thinner margin of health” (Institute of Medicine (IOM), 1991,), the medical, functional, and psychological consequences of not receiving appropriate health care in a timely fashion—and the practical implications for their level of independence and social and economic participation—are often considerably magnified (Coughlin et al., 2002; Neri & Kroll, 2003).

2.5 Frameworks for Understanding Health Care Access Barriers

While many health care access barriers have been described in the literature, they have generally not been incorporated into models that set access barriers as units of analysis; classify barriers; and provide frameworks that facilitate measurement, analysis, and reporting (DeVoe et al, 2007) .Some of the models identified from the existing literature are discussed in the coming paragraphs.

Andersen's Behavioral Model of Health Services Use is a well-known and frequently applied model of access to care. This model sets the individual as the unit of analysis and suggests that the individuals' use of health services is a function of their need and predisposition to use them. Andersen's model serves as a framework for large scale studies and incorporates a comprehensive and wide array of determinants. Determinants include demographic factors (age and gender), social structure (education, occupation, ethnicity, and other factors measuring status in the community, as well as coping and the health of the physical environment), and health beliefs (attitudes, values, and knowledge that might influence perceptions of need and use of health services). A number of variations of the Andersen model have evolved over the years, but all subscribe to the same fundamental characteristics (Goldsmith, 2002)

The Health Care Access Barriers (HCAB) Model is another framework that facilitates the design of community health interventions by targeting measurable and modifiable determinants of health status. This is different from the Andersen Model, which provides a broad framework of modifiable and non-modifiable determinants and is ideal for large-scale studies of health. The HCAB is not a comprehensive model that attempts to include all determinants; rather it targets modifiable health care access barriers in order to serve as a practical tool for root-cause analysis and community-based interventions (Haynes, 1976).The model provides a nomenclature and framework for identifying, categorizing, and targeting health care access barriers. It describes three categories of modifiable health care access barriers (financial, structural, and cognitive). It is also argued that these three types of health care access barriers are associated with decreased screening, late presentation to care, and lack of treatment, which in turn result in poor health outcomes and health disparities. By targeting those barriers that are measurable and modifiable, the model facilitates root-cause analysis and intervention design.

Over a number of years, the lead author and colleagues have developed a health care access barriers model that is rooted in the social and cultural barriers that limit doctor-patient interactions. Multiple health care access barriers facing Hispanics were noted through interviews and focus group studies supported by the Robert Wood Johnson Foundation in 2001. These access barriers have been classified and sorted into categories. In addition, a review of the literature yielded three intermediary variables that link these access barriers with poor health outcomes. Here we articulate a model oriented specifically to health care access barriers that proposes mechanistic links between three categories of access barriers and subsequent health disparities. The fundamental characteristics of the HCAB model are classification of health care access barriers; identification of barriers that are measurable, modifiable, and identified using the best available evidence; and recognition of intermediary factors that link barriers with health outcomes (Aguirre-Molina M, Carrillo JE., 2001).

The HCAB model sets health care access barriers as the units of analysis and provides an approach that focuses on the causal pathways between the access barriers and the adverse health outcomes. This differentiates HCAB model from the Andersen model, which sets the individual as the unit of analysis. The previously cited DeVoe model addresses financial and structural barriers, but it does not explore cognitive barriers, which have also been shown to limit access. These three categories of barriers are reciprocally reinforcing and affect health care access individually and in concert. Cognitive barriers may aggravate or compound financial and structural barriers. Similarly, financial barriers may lead to structural or cognitive barriers. The HCAB model also defines three intermediary variables (prevention, timely care, treatment) that can serve as intermediary measures reflecting the impact of access barriers (Betancourt JR et. al,1999)

2.6 Barriers of Accessing Primary Health Care Services

A growing number of publications document that people with disabilities experience barriers in the delivery of appropriate primary and preventive health care (Kirschner, Breslin, and Iezzoni, 2007; Panko Reis, Breslin, Iezzoni, Kirschner, 2004; Parish and Huh, 2006; Scheer, Kroll, Neri, & Beatty, 2003; Neri and Kroll, 2003; Drainoni, et. al., 2006). These barriers are present for those with public as well as private insurance coverage.

Barriers to access are those factors that contribute to preventing a person from utilizing a service when needed (Scheer, Kroll, Neri, & Beatty, 2003). Scheer et al. (2003) identified two broad categories of barriers to health care services: structural environmental barriers and process barriers. Structural environmental barriers are impediments to medical care directly related to the number, type, concentration, location, or organizational configuration of health providers. They include issues of accessibility, geography, technology and location and doctor's offices. Process barriers relate to the delivery of service. For example, lack of provider knowledge, bad attitudes and lack of timeliness of service from providers are issues frequently reported by patients.

A qualitative study by (Walji, 2012) in Cambodia on access barriers to health services for people with disabilities found out the following barriers to access health care services:

a. Finances namely transport costs to the health facility, unofficial user fees and the costs of a carer to accompany the person with disabilities.
b. Quality of care, particularly health professionals' knowledge and skills related to disability as well as their discriminatory attitudes based on the patient's ability to pay

c. People with disabilities, having poor knowledge of where to seek appropriate services and of their rights and entitlements.

d. Socio-cultural negative beliefs and attitudes associated with disability

e. Long distances to health facilities, lack of appropriate transport options and inaccessibility of health facilities.

In Africa, rural/urban disparities loom large and services are in short supply as a result of geographic isolation, poverty, illiteracy, distances, transportation difficulties and related factors, all of which make delivery of health care for people living with impairments challenging. This reinforces the statement by Brems, Johnson, Warner and Roberts (2006) that:

> Optimal healthcare delivery, regardless of location, is technology-demanding, costly without economies of scale, and dependent upon availability of skilled workforce. These features of healthcare systems are difficult to satisfy, even in urban areas. In rural areas, the health care system features of optimal health care delivery, in combination with rural limitations, make development and maintenance of efficient and effective healthcare delivery difficult (Brems et al.,2006:1).

A study by Veltman, Stewart, Tardif and Branigan (2001) showed that people with disabilities often lack opportunities to engage in preventive healthcare activities and do not have adequate access to primary healthcare, hospital care, and long-term care.

People with disabilities often report that they must spend considerable effort educating their primary care providers about their disability and they feel that doctors sometimes focus inappropriately on the disability itself rather than on the health problems with which they present. Factors that impede adequate primary healthcare have been well demonstrated to include: unmet transportation needs, lack of provider knowledge regarding disabilities, refusal of medical treatment by a doctor because of a disability, architectural barriers such as lack of adequate ramps into healthcare facilities and inaccessible examining tables, poor coordination of healthcare services, and negative attitudes of healthcare providers toward people with disabilities (Veltman, et al.,2001). Goudge, Gilson, Russell, Gumede and Mills (2009) argue that key barriers to care are unaffordable costs to households, weak availability of inputs and services, and poor acceptability (the appropriateness of the social interaction that accompanies care), collectively referred to as the access framework. In low and middle income countries, patients often either do not seek care, or do so only when they have access to funds, thus affecting continuity of care. Shortage of health service inputs (staff, drugs, and equipment) often mean that appropriate care is not available.

2.6.1 Structural/Environmental Barriers

According to a study by Carrillo JE (2005) Structural barriers are defined by the health care system's availability. Such barriers may be found within or outside of health care facilities. These barriers act independently or concurrently with financial barriers already facing those without insurance. Structural barriers may occur externally to the processes of care, as when people seek access to health care services. These barriers, as defined by recent studies, include but are not limited to availability and proximity of facilities, transportation, child care, and structural characteristics of care. Structural barriers are often experienced within the health care facility. Barriers such as excessive waiting times may affect care-seekers who have low incomes and live in neighborhoods of social and economic distress. Financial and structural barriers may be further compounded by cognitive access barriers that may, alone or in combination, adversely affect disease prevention and health care. This section will look at different forms of structural barriers. These include the following:

2.6.1.1. Physical Accessibility

In Zimbabwe, Choruma (2007), reports that although most new buildings have ramps with rails, in many cases the recommended gradient of the ramps is not adhered to. The buildings may also lack signs to indicate where the physically impaired entrance, elevators or toilets are located. In urban areas, a door to an office or toilet is heavy and handles placed too high making it difficult for a person in a wheelchair to enter.

Consumer satisfaction refers to attitudes toward the medical care system of those who have experienced contact with health facilities. Iezzoni et al (2002) mentioned that the structure of the health care delivery system could affect satisfaction for persons with disabling conditions. Managed care health plans, which limit access to certain providers, pose logistical barriers to obtaining care. For example, since they cannot drive, some blind persons rely on public transport to move about their communities. If plans do not include providers on convenient bus or underground train routes, this could impede the physical ability of some visually impaired persons to reach care. Thiede and McIntyre (2008) argue that social exclusion may result from a lack of mobility aids, or inaccessible built environment. Kroll, Jones, Kehn, and Neri, (2006) argue that it is of utmost importance that facilities at health centers are user-friendly. The term user friendly means that service providers should not make it difficult for the patient to get the treatment that they are looking for at the clinic. They should accommodate those in wheelchairs especially by building of stairs and toilets. Shelf heights should be convenient for both standing and seated users.

2.6.1.2. Provider's Offices

Health care service providers' offices have been said to lack equipment and space essential for treatment of patients using wheelchairs. Medical equipment is often not accessible for people with disabilities, particularly those with mobility impairments. The WHO and the World Bank (2011) state that men with disabilities reported health service provider's equipment (including medication) to be inadequate across income settings (22.4% compared with 7.7% for men without disabilities); women with disabilities reported similar difficulties. For example, many women with mobility impairments are unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand (World Health Organization & World Bank, 2011).

In their survey of over 2,300 primary care facility sites in California between 2006 and 2010 (Mudrick, N.R.; Breslin, M.L.; Yee, S.; and Liang, M ,2010) found out that only 3.6% had a wheelchair-accessible weight scale and 8.4% had a height-adjustable exam table, basic equipment that is necessary so people with a range of mobility limitations can transfer safely for examinations. At the same time, Africans with severe health disabilities are less likely than whites to access health services, more likely to drop out of treatment, more likely to receive poor-quality care, and more likely to be dissatisfied with care.

2.6.1.3. Health Costs

According to Etowa, Wiens, Bernard and Clow (2007b) poverty is a determinant of health because it restricts access to health services and treatment. Chipp et al (2010) showed that rural residents incur more expenses travelling to regional centers to receive healthcare because such care does not exist in their local community and/or facilities. In the study by Etowa et al (2007) about 57% of the respondents reported that they did not have enough money for medication. Furthermore, women failed to seek medical attention because they could not pay for travel to the clinic. Similarly, Turner Goins, Hays, Landerman, & Hobbs, (2001:p. 210) found that "financial constraints posed considerable barriers to accessing needed health care among study participants, including issues related to health care expense, and inadequate health care coverage".

The research of Hwang et al (2009) demonstrated that people living with disabilities need a wider range and depth of services than other patients and this resulted in higher costs of health care for them. In Namibia where most people with disabilities are not employed (and do not have insurance coverage of any kind) the costs of transport, medicine and other services can be prohibitively high. According to the WHO and World Bank (2011):

> The rate at which people with disabilities pay with current income or savings is roughly the same as for people without disabilities, but paying with personal means varies between groups: paying with insurance is more common in high income countries, while selling items and relying on friends and family is more common in low income countries, and people with disabilities are more likely to sell items, borrow money, or rely on a family member. People with disabilities experience lower rates of employment, are more likely to be economically disadvantaged, and are therefore less likely to afford private health insurance. Employed people with disabilities may be excluded from private health insurance because of pre-existing conditions or be "underinsured" because they have been denied coverage for a long period, or are excluded from claiming for treatment related to a pre-existing condition, or must pay higher premiums and out-of-pocket expenses (WHO and World Bank, 2011:66).

Financial barriers may restrict access either by inhibiting the ability of patients to pay for needed medical services or by discouraging physicians and hospitals from treating patients of limited means (Drainoni et al., 2006).

2.6.1.4. Geography, Distance and Transportation

Geographical conditions greatly affect access to health services. In general, people in mountainous areas (regardless of economic status) access health services less frequently than people in areas without mountains. Geographical access is measured in distance and time to health facility and these indicators are worst in the North West Mountains and Central Highlands in Vietnam (Oanh, 2009).

Geographical challenges such as mountains, gullies, rivers, unpaved roads etc. present physical barriers to accessing healthcare. “Due to these geographic challenges, some rural residents make trade-offs between their safe travel in inclement weather and accessing health care in a timely manner” (Chipp et al. 2010). “Generally, the more remote the area in question, the greater the problems of access to medical care due to geographic distances, transportation problems, lack of insurance, and an inadequate supply of local providers” (Lishner, Richardson, Levine & Patrick, 1996). Brems et al. (2006) argue that travel distance negatively affects access to health services for rural more than urban patients. Moreover, due to distance and access restrictions, rural residents with a chronic illness may not receive information on new treatment strategies (Chipp et al. 2010). Rural residents also have very “limited access to specialized providers and consultants (i.e. cardiologists, oncologists, psychiatrists), and additional resources due to the rural geography” (Chipp et al., 2010).

Similarly, Caldwell (2008) found that for families with developmental disabilities, the greatest out-of-pocket costs included transport. Lack of transportation options present an additional obstacle to rural dwellers accessing healthcare (Lishner et al., 1996). Brems et al. (2006) found that lack of access to services due to transportation difficulties were reported overwhelmingly more by rural than urban providers.

2.6.2. Process Barriers

Process barriers are difficulties in the course of delivery of service (Scheer et al, 2003) .For example, lack of provider knowledge, communication and attitudes, acceptability, availability and quality of health care issues are frequently reported by patients. Financial barriers may restrict access either by inhibiting the ability of patients to pay for needed medical services or by discouraging doctors and hospitals from treating patients of limited means. Personal and cultural barriers may inhibit people who need medical attention from seeking it or, once they obtain care, from following recommended post treatment guidelines.

2.6.2.1. Communication and Attitudes

Communication difficulties between people with disabilities and service providers are regularly cited as an area of concern (Smith, 2009; Ubido, Huntington & Warburton, 2002). Communication differences pose an impediment to effective and ethical rural health care. More nurses/doctors who understand sign language should be trained and employed in the health sector in order to be able to communicate with those who are deaf (Kroll et al. 2006).

Barriers, such as an inability to provide health information in plain text or sign language, constitute violations of rights to equal treatment and equal opportunities (Tomlinson et al., 2009). Hwang et al. (2009) report that people living with disabilities experience insufficient communication with providers. People with severe learning and communication difficulties may not be able to express discomfort or pain in usual ways. Care providers must be aware of this and sensitive to changes in behavior or well-being that indicate pain, illness or unhappiness (Lindsey, 2002). Hence, access reflects the interplay between the supply side and the demand side in health care. Issues of language seem to be related to issues of ethnicity. “Racist attitudes of health-care providers present an obvious barrier, the lack of diversity among health-care personnel also makes it difficult for some women to access suitable health-care providers” (Etowa et al., 2007). In this context, the WHO and World Bank (2011) argue that “Negative attitudes and behaviors have an adverse effect on children and adults with disabilities, leading to negative consequences such as low self-esteem and reduced participation. People who feel harassed because of their disability sometimes avoid going to places, changing their routines, or even moving from their homes” (WHO & WB, 2011).

2.6.2.2. Knowledge of Service Providers

Some facilities lack knowledge. This is brought about by insufficient training and limited number of health care workers. This problem is not only limited to poor countries but also affects rural places in developed countries. For example, Turner, Williams, Carter, Spencer & Solovieva (2005) found that in Canada there were “Concerns about the limited number of physicians and long-term care options. Discussions about the limited number of physicians included difficulty with recruitment and retention, need for more specialists, overall limited choice of physicians, and aging of local doctors”.

In a study by Becker et al. (1997) women described providers as insensitive or lacking awareness of disability issues as they impact reproductive health care. Veltman et al. (2001) found that many patients felt they had unmet primary healthcare needs because their family doctors lacked education regarding physical impairments. Doctors, families and society as a whole do not understand or know much about physical impairments.

Those who have impairments within societies find it hard to have their health care needs taken care of because those who are supposed to take care of them do not understand their problems. Neri and Kroll (2003) found that relationships with family and friends had been affected because of not getting access to needed primary care services or durable medical equipment. The WHO and WB (2011) concluded that generally, a better knowledge base is required on the prevalence, nature, and extent of disability - both at a national level where policies are designed and implemented, but also at global level with changes monitored over time.

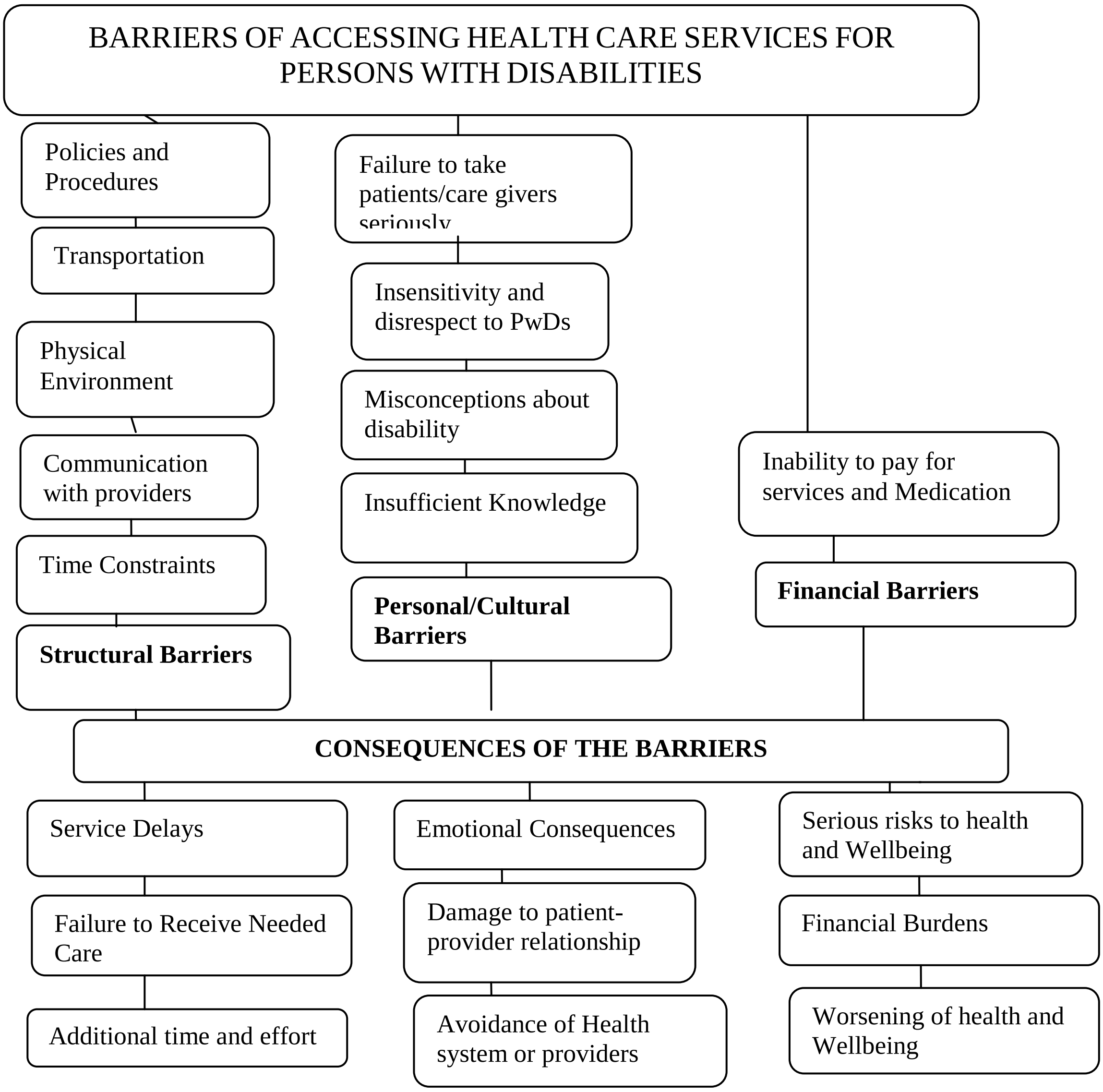
Another survey by McNeal et al. (2002) found out that the majority of primary care physicians have at least some difficulty in examining patients with physical disabilities and many are uncomfortable in managing their care. A lack of training in medical school and in residency programs was noted as contributing factors and suggests the need for disability awareness training for primary care physicians.

While some authors have classified barriers as above, Carrillo (2005) has classified barriers according to Primary Access Barriers, Secondary Access Barriers and Tertiary

Access Barriers. Primary access barriers include health insurance, which comprises lack of insurance, underinsurance, and inability to pay for care or treatments. Secondary Access Barriers comprise organizational and systems of care. These are all barriers encountered between home and providers' office: availability of care, transportation, childcare, waiting times, etc. He identified the problem under secondary access barriers to be that patients at 'Risk who access the health care system face organizational and structural barriers (organizational related to leadership/workforce and structural related to systems of care).This result in decreased medical screening, late stage of presentation, and insufficient treatment resulting in more costs for the consumer. Tertiary access barriers are the communication problems between the provider and patient when language and culture hinder provider-patient communication. In the tertiary barriers, there are socio-cultural differences which lead to less effective care due to poor communication, different beliefs about illness and treatment, poor adherence to therapeutic plan, limited health education, provider bias and stereotypes.

Rogers (1973, cited in Loue, 1998), on the other hand, identified barriers to access as the shortage of primary care doctors in the inner city and rural areas. Other studies considered the consumers' willingness to seek care (Mechanic, 1972) and financing or reimbursements (Fox, 1972).Hwang et al (2009) concluded that whereas most individuals tend to be satisfied with the overall competence of doctors, many believe that providers need to know more when it comes to dealing with people living with disabilities.

Figure 2.1. Conceptual Framework



Source: Adapted from Institute of Medicine (IOM) Framework

Chapter Three

Research Methodology

3.1 The Study Area

The study is conducted in Gulele sub city. The sub city is one of the ten sub cities of Addis Ababa. According to the 2007 population projection, its total population is estimated to be 346,023 out of which 169,155 are male and 176,868 are female. However, there is no well registered statistics showing the number of Persons with Disabilities in the sub city. But in 2007, the Social and Civil Affairs Department of Gullele sub city Administration has conducted an assessment study on Persons with Disabilities in general. According to this document, the total number of Persons with Disabilities in the Sub- City is estimated to be 2,890. This statistics is a crude amount and it does not identify the number of Persons with Disabilities in terms of sex and disability types. To study the perceptions of service providers on the primary health service delivery, all of the health centers in the sub city are included in the study. These are Selam, Gutomeda, Maychew, Hidasie, Shiromeda, Tibebebekechene, Addishiwot, Entotofana, Addisugebeya and Shegole Health Centers.

3.2 Study Participants

Persons with visual, hearing and physical impairments are the major participants of this research. But to support the data from agency or health service providers' perspectives, Health professionals (Health Officers, Health Extension Workers and Nurses) and health administrators from selected health centers are part of this research. The participants from health service providers are taken from Selam, Guto Meda, and Maychew health centers in Gulele sub city which are selected based on their performances obtained from the sub city health office with high, medium and low performances respectively.

3.3 Study Design

The research entirely depends upon qualitative design. There is agreement that good qualitative studies answer clearly stated, important research questions (Frankel & Devers, 2000).According to Babbie and Mouton (2001), qualitative research is defined as describing and understanding rather than the explaining and predicting human behavior. Sarantakos (2005) has argued that there is not one but many qualitative methodologies; thus the need to make it clear on the type of qualitative methodology one uses. This study used semi-structured interviews and focus group discussions. Focus group discussion (FGD) and in-depth interview are the two major methods employed by this research as primary sources of data. These methods were selected by the researcher because, they have been found to be more appropriate to gather deep information on the subject and allow flexibility when running different sessions of interviews, which help to clarify unclear questions and pick important cases needed for the research. Observation is also used to confirm the data concerning the situation of physical barriers at each of the health centers.

The qualitative method used throughout this research is Phenomenology. Phenomenological qualitative method is suitable for this research because it is important to identify phenomena through how they are perceived by the actors in a situation. The research tried to find out the perception of service users and providers about the barriers of accessing primary health care services.

3.4 Sampling

Purposeful sampling is used for the recruitment of participants for this study. Purposeful sampling is commonly used in qualitative research. It involves selecting research participants according to the needs of the study (Glaser & Strauss; Morse, 1991) in that researchers choose participants who give a richness of information that is suitable for detailed research (Patton, 1980). Both stakeholder and criterion purposive sampling techniques are used for this research. Stakeholder sampling is important because the individuals for this study are accessed via the key agencies working on the problem under investigation. The selection criteria for inclusion are persons with disabilities (persons with visual, hearing and physical), service providers (Health Officers, nurses, health extension workers and administrators) from health centers but those who lived more than six months in Gulele Sub City.

3.5 Pilot Test

Pilot test was carried out on a total of six individuals in Gullele Sub City. This was done to ensure the feasibility and clarity of some of the interview guides designed for the interviewees. Based on the pilot test, some necessary modifications were made on the questions. Moreover, to prevent the contamination of as a result of piloting, the researcher excluded the six individuals in the actual data collection process.

3.6 Data Collection Procedures

Three different checklists (one for the FGD, one for observation and the other for the in-depth interviews) are prepared, which the research is guided by during running the FGD, the observation and the interview sessions. The checklists consist of questions that were believed help the research explore the aforementioned issues. The FGD and the interviews made with the respondents are recorded by cassettes through their permission as backups in addition to the notes that the researcher keeps. The researcher first informed them about the research and its objectives and asked their willingness to be interviewed and when they agreed, also asked whether they volunteer to be recorded or not. Then, when they express their consent, the sessions started to be run. For easily contacting and collecting the data from health service users, the researcher approached National Associations of the blind, deaf and the Physically Handicapped.

3.7 Data Analysis

The researcher kept short notes for both the interviews and focus group discussions. The notes are expanded after each of the in-depth interviews and focus group discussions with in 24 hours in the form of statements. All interviews are also audio-taped as back up to the notes. After reviewing the expanded interview notes, analysis of interview data began with coding into broad categories dictated by the interview questions. Content and thematic analyses are the main techniques for data analysis. The health care access barriers model is also used to classify the barriers in the findings section of the thesis. For assuring the quality of the data the researcher analyzed it from the perspectives of service users and service providers.

3.8 Ethical Consideration

As disability and health are sensitive issues, they need to be carefully considered in any research. In this regard, official ethical clearance is secured from the school of social work and Addis Ababa City Administration Health Office. On the other hand, the researcher first introduced the purpose of the study to the study participants. Then, the privacy and confidentiality of all participants of this study are addressed before the collecting the data. The participants are informed that all the information they provide would be kept secret. Besides, the anonymity (not exposing their personal issues to others or secrecy) of the participants is maintained during and after the data collection. The data was collected after oral and written consent of the participants.

Chapter Four

Finding and Discussion

4.1 Socio-Demographic Characteristics of Participants

4.1.1. Participants from Health Service Users

Participants of the in-depth interview from health service users were eighteen in number among whom seven were visually impaired, five were deaf and the remaining six were physically disabled persons. Three of the visually impaired and two of the physically disabled were females and four of the visually impaired and four of the physically disabled were males. Two females and three females were deaf participants. Totally, eleven of the respondents were males and the remaining seven were females.

Regarding their educational level, four of the physically disabled were diploma holders and one deaf participant had a master's degree while six of the participants have first degrees in different fields. The other four participants completed grade 12 in the old curriculum. The remaining three participants completed grade 10.Their age ranges from 23-50. Eleven of the respondents reported that they are employed while the remaining seven are dependent on their parents and relatives.

When we come to the background of participants of the Focus Group Discussion from the health service users, five of them were males and the rest three were females. Three of the participants had 12+2 and another one had 12+4 level of education. The rest four just completed grade 10.Concerning their disability types, two of them were deaf and three of them were visually impaired. The rest three were physically impaired.

Table 4.1: Summary of Participants from health service Users

S.N.	**Type of dis-ability**	**Gender**		**Age range**		**Educational Level**					**No. of participants**
		Male	Female	20-35	36-65	10th	12th	Diploma	1st Degree	2nd Degree	
1	Blind	4	3	2	5	-	2	-	3	-	7
2	Deaf	3	2	4	1	-	2	-	1	1	5
3	Physical	4	2	3	3	3		4	2	-	6

4.1.2. Participants from Health service Providers

Participants of the in-depth interview from health service providers were nine in number among whom three were health officers while three of them were clinical nurses. The remaining three were health extension workers. Six of the participants were females while the rest three were males. Regarding their educational level, four of them were diploma holders in clinical nursing and five participants are degree holders in health officer. Their year of professional service ranges from two to thirty years while their age ranges from 24-52.

When we come to the background of participants of the FGD from the health service providers, a total of eight health practitioners participated. Only two of them were males and the rest six were females. Six of the participants hold Diploma in nursing and the rest of them were degree holders in health officer.

4.2 Structural-Environmental Barriers to Health Service Delivery

Environmental-architectural barriers are conditions in the physical environment in which health services are delivered. These include transportation, outdoor and indoor environment of the buildings such as approach road, entrance-exit, waiting rooms, washrooms, toilets, beds and tables with adjustable-height, etc.) where health services are provided (Kroll et al, 2006).Such barriers typically consist of lack of accessible ramps at health centers which also includes rooms and equipments that are difficult to reach by persons with disabilities and the unavailability of needed transportation services to medical appointments (Kroll et al., 2006 & Hwang et al., 2009). Forms of Structural-Environmental barriers identified by the study are discussed in the following subheadings.

4.2.1. Physical Barriers

Almost all of the participants confirmed that the design of the health centers is not disability friendly. Physical accessibility depends on the type of disability suffered and the design of the health center. For example, those in wheelchairs have problems of access buildings while the visually impaired and those with upper limbs disability do manage to access easily. This was not so much of a big issue to a lot of people in the sites studied. However, one respondent in Wereda 4 reported that: "It is difficult for me to access the health centers because there are no lifts and the ramps are up to the first floor."Also another respondent put it this way:

> The Health center is not accessible to me as a physically impaired person and there are no porters who can help us at this facility. No toilets for physically impaired people and no path entrance for us. Examination room is not accessible unless someone lifts me - that is when I go in the examination room. (Male, Physically Impaired)

The other respondent also marked that:

> The absence of a ramp to all the floors in the environment including health facilities is the challenge to get services as needed. I need an accessible exam table and entrances not to beg others. People carry me to the exam rooms and I do not feel comfortable because some people comment on my weight. Other people opt to do all the processes by themselves rather than to carry me from room to room (Female, Physically Impaired).

One of the respondents, who is serving as a nurse in Guto Meda Health Center, pointed that the design of the health center is not built considering the needs of persons with physical impairments as follows:

> The design is made at the City level and most of the health centers are constructed based on this design. It is not inclusive of persons with physical impairments. These people only can access services up to the first floor. But other services like family planning, antenatal care, Voluntary Counseling and Testing (VCT) are inaccessible because they are above the first floor (Male, Clinical Nurse).

Not only are the entrances and the floors inaccessible but the toilets, the exam rooms and the exam table itself are not accessible to persons who use wheelchairs and crunches in health centers as a respondent indicates:

> I believe that I could not get health care services as the same as the other population because of many reasons. The services are not physically accessible for persons with disabilities. The toilets and the examinations rooms are not comfortable for me. Once I entered the health center and there are no elevators or lifts to go to the exam room. People carried me and they just dropped me to the exam room. The doctor asked me to bring sample for laboratory investigation but when I approach the toilet the nurse told me not to go the toilet because it is not comfortable for me to use. At that time I become nervous and told her to call the doctor. She shouted at me and told me that I came here not being sick but to create chaos. The Doctor came and I told him that this is not my problem and he has to treat me soon.(Female, Physically Impaired)

4.2.2. Location of Health Centers as a barrier

Respondents from two Weredas, especially those living in Wereda 2 and Wereda 4 area complained of the long distance to the nearest health center since it is situated far from their villages. For these respondents, distance was a problem. For service users who are physically impaired or blind it is difficult to walk to the health facility. This means that without transportation even a short distance to care facilities can become an insurmountable problem. A participant illustrative: “It took about half an hour to get to the health center. The village is not far but because we both can’t see, we walk slowly just to make sure there is nothing on the way and find foot path using a stick. Another service user also pointed out "I am also not happy with the location of the facility because my village is too far. When you walk it takes more than 30 minutes to get to the health facility if I travel without assistant."

It is acknowledged that access is a problem for the poor and other vulnerable group but people with physical impairments have a double burden. A number of people in the focus group highlighted distance as a major barrier to access health care services as a service user indicated "Long distances are the major problem for us to access health care and it is so difficult for persons like me to travel even very short distance to reach to the taxi when I become sick."Another participant of the focus group discussion reported:

> I cannot walk properly. My leg and arm were broken few years ago in an accident. We should be provided with a mobile health facility that must be treating physically impaired people who cannot walk to access health care. The fact that there are no staffs who are physically impaired like us shows that they must employ people who are also physically impaired because they will know how we feel.(Male, Physically Impaired).

For persons who are blind the location of the health centers matters because they simply search the facility only using their pointing stick. The nature of the road between the health facility and their home is very critical which is directly related to the location of the health center. One of the participants explained this problem as follows:

> Blindness for persons whose sight is lost in recent times is so difficult even to move from place to place. I fear to walk by myself because I wonder if I fall in to an opening while walking. My fear was realized once falling to a well and my leg was injured. The problem is intensified when the location is not closer to the main road and if it is necessary to go on foot. (Female, Blind).

Another participant with participant with visual impairment also reported that:

> Persons who are blind could not get health care services as the same as others without disabilities because the environment is not comfortable for us beginning from the roads to clinics. The services at the health centers are not easily

> traceable by persons who are blind. Finding a room at a building is one of the issues of concern because we cannot see the number of the room even if we could go up to the floors of the building.(Male,Blind).

A health service provider also recommends that health care facilities should be constructed considering the needs and the users of the services but the new health centers are built at places which are free for constructing the buildings not considering who uses the services. He argued that people when they become sick, it is hardly possible to reach even short distances. He believes that “The physical locations of the health facilities should be more accessible and closer to the community so that all the populations could access them easily. It is not easy to go to a health center when people are sick.”His arguments confirm that the locations of some of the health centers under this study are constructed based on the needs of the surrounding community. Another service provider also marked that “one of the reasons why people do not come to this facility is that the its location is not closer to the residents of the Woreda”

4.2.3. Inaccessible Transportation

Transportation is a major barrier for the respondents with mobility impairments. Public transport was not an option for those who were using tricycles or wheelchairs. Consequently, the reason why they were not using public transport was of great interest. One participant, who was on wheelchair pointed out that:

> Local transport services have no proper arrangements for persons on wheelchair to get on board, hence, operators/drivers often deny me to board on this so-called transportation. I cannot go outside and anywhere from my village without any specially-hired transport and assistant which is not affordable all the time. So, I have to rely on nearby local quack and traditional healers for treatment. (Male, Wheelchair user).

Transportation is one of the most worrisome problems people with disabilities face. For some, location provides other physical barrier to accessing health facilities as comments under the location theme have shown. Form of transport to/from the health facility is important in any consideration of transport. Although access to transportation is the same for all groups of people in society, persons with impairments face difficulties in accessing transportations because of inaccessible doors of public buses. They have to ask people to take them in to the bus. One of the respondents who is a residence of Semien Hotel area explaining about this barrier marked:

> It is hard to use public transport for me because I cannot enter with my wheelchair. I have to ask people to carry me from my wheelchair to the bus and always asking this is an acceptable for me because of this I do not want to use public transportation.(Female, Physically Disabled).

The other barrier explained by the users of the services related to transportation is the bad attitudes of individuals working in the transport sector regarding persons with disabilities. Taxi drivers, assistants and taxi service users do not understand the rights of persons with disabilities to use the transport service equally with the other population. These concerns are explained in one of the respondent's words as follows:

> Transportation is the biggest challenge to come to the health facilities for persons with disabilities. Misunderstandings by the drivers, the assistants and the general public are still a big problem. I am regularly requested to pay to get a sit, for my wheelchairs. I also encountered people who do not want even to share a sit with me in a taxi. One day when I got a sit near a man he stood and went out of the taxi because he has a bad attitude towards me. Most of the times the taxi drivers and assistants do not want us to enter because of their low awareness about disability. (Female, Wheelchair user).

Persons who are deaf also complained about the barriers of using transportation services because of communication problems with assistants and the change in the directions of the taxis as one respondent who use a taxi explains:

> It is difficult for persons like me who are deaf to use transportation to heath facilities because we cannot communicate with assistants and drivers about the route of the taxi. Once I entered in to a taxi just by reading the poster at the top of it but the driver started to drive in another route and I shouted to stop it. This happens many times for me.(Female,Deaf).

Although policy instructions are in place to make outdoor environments and public buildings barriers-free and accessible for disabled persons, however, in most cases health outlets were reported inaccessible. Poor approach roads/entrances, and improper waiting places and washrooms were the major obstacles that restricted the movement of individuals with mobility impairments. For instance, responding to the question “how he/she feels about the outdoor and indoor environmental arrangements of health centers” one female respondent mentioned that:

> There is no smooth approach and ramp to reach the entrance and enter the building, thus traversing uneven slopes in zigzag manner becomes frustrating and exhausting for my arms to drag the wheelchair. Furthermore, there is no proper waiting room and disabled-friendly toilet arrangements and facilities.(Male, Physically Impaired).

Based on the above responses it can be argued that policies ask to build barrier-free environment with the sophisticated understanding of the rights persons with impairments in terms of their independent mobility. What is discriminatory at the service delivery level and is often overlooked in the process of providing the structures of aiding for the disabled in any environment is the negligence of the rights of this section of the population. The issue of disability is not well mainstreamed while constructing the services at the facilities. Hence, no strict regulations and concerted efforts exist at the implementation and managerial levels to ensure the free-mobility of disabled persons as a matter of their citizenship and rights that would have enabled them to pursue their day-to-day tasks.

As respondents confirmed, there are people who feel sympathetic when they see people with disabilities but this should not be simply expressed by shaking heads. It has to be internalized and people should try to help people in designing and implementing regulations are unable to use services because of the barriers as one respondent pointed out:

> People only feel sympathetic about our cases. I do not want that because what matters for me is to help us get the services as the other population. Services are designed and provided by people if they well understand disability they could have made it disability friendly.(Female, Blind).

From these above findings, it can be argued that the concerned duty bearers such as local political actors, policy makers, and service delivery players have no proper understanding of the secondary conditions that impede the disabled individuals from attaining their health rights. Such factors are rarely taken into account while developing health care inclusive with the main aim of providing greater access to people living with disabilities. Concerning this point, one of the health care providers marked, “I believe that there is lack of political commitment in the health sector.”

4.2.4. Resource Constraints as a Facilitating Factor behind the Barriers

Ethiopia is among countries with lowest health status in the world. This is mainly due to backward socio-economic development resulting in widespread poverty, low standard of living, poor environmental conditions and inadequate health services (MOFED, 2002). As with other developing nations, Ethiopia has experienced extreme resource constraints within the health care system.

Both participants from service providers and users repeatedly marked that lack of financial resources is a major barrier to access health care for many people, because the impact it has appears to be greater for vulnerable groups including people with different impairments. Persons with disabilities have to cover the cost of transportation and costs related to health care services.

People with disabilities have fewer economic resources compared to their non-disabled counterparts. Most of the time it is difficult for them to get jobs to be able to sustain themselves and if they get these jobs, it is usually difficult for them keep it thus they remain in poverty (Etowa, Keddy, Egbeyemi & Eghan, 2007).

For a variety of reasons, according to Neufeldt and Albright [1998: 5], "disabled people have found it inordinately difficult to participate in the economic benefits of their countries to the same extent as those with no disabilities. This has been true in both low and high-income countries, though citizens of low-income countries often face the greater disadvantage", which shows the universality of the problem. For example, in Ethiopia, a study conducted by Terusew and his colleagues [(1995) revealed that 60% of PWDs were unemployed and among those who were said to be employed, 64% were living in rural areas engaged in their own small agricultural, animal husbandry and forestry activities. Only 3.1% were working on professional and technical jobs, and at the time of the study, no disabled person was reported to have been employed on administration and management positions.

The above literature strongly support the ideas of the participants that those who earn better income from persons with disabilities could address some of the barriers for accessing primary health care services. This is because they can pay even to people who assist them and use health facilities accessible for them from the private health facilities. Those who have enough money from persons with disabilities are able to get better access to services as one of the respondents indicates:

> I believe that the biggest challenge is the level of poverty. It is both the cause and very important factor which aggravates the life of persons who live with disabilities. I am blind but I have a degree and licensed as a public prosecutor.

> I can work as any person since I am capable economically. I seek health care in private health facilities since I can pay for the services. But I still believe that persons who use crunches and wheelchairs face physical accessibility challenges not only in health facilities but at all buildings and the environment. Do not get sick in this country especially if you are poor because the services are poor and no one will help you urgently. (Male, Blind).

Almost all of the participants confirmed that being poor is the biggest challenge for persons with disabilities since most of them engage in begging and become idle being dependent on their relatives as one participant from the focus group discussion put:

> One of the major barriers for persons with disabilities for accessing services is poverty. They are poor and engaged in begging or living as dependants to their families and relatives. This is one of the reasons why they could not come to the health facilities despite that they are vulnerable to infections because of poor sanitation or personal hygiene. The other reason is they need assistants to get services in their home or in the facilities.(Female, Blind.)

Using public services like the toilets exposes persons with disabilities to infections and diseases since the quality of the services is very low as another respondent also added:

> Being disabled exposes persons with disabilities for poor sanitation if they are living in a poor environment. The personal and environmental hygiene coupled with disability aggravate infections and diseases. The public toilets are not accessible and comfortable for the disabled.(Male, Blind).

In-depth interviewees reported that being poor is the reason for being exposed to diseases and disability itself. One of the causes for being disabled is inability to get urgent medication during accidents. One participant who was disabled by a car accident believes that her disability could have improved if she got emergency treatment as soon as the accident happened. She explained as follows:

> I was disabled 10 years ago because of a car accident while travelling from Addis Ababa to Ambo to visit my sisters and brothers who were alone since

> our parents died. My spinal cord was injured and Because of inaccessible emergency medical care urgently at that time. I was refereed and taken to Black Lion Hospital but because of high number of people admitted to the Hospital I could not even get bed. Horribly, I slept on the ground for a month with lots of injuries on my body which resulted in damage of my nervous system. I could have stood and walked if I got emergency care just after the accident. (Female, Physically Disabled

Participants of the focus group discussion also confirm that "Most people with disabilities are living in poverty because of the attitudes of the community and they are also illiterate. They themselves are not aware of their potentials. These are the reasons why they fail to work for their rights."

The beginning of giving free access to health facilities is recognized by both the health service users and service providers. Almost all of the participants agreed that free health care service is available if the user could bring a letter from the Wereda or the association the patient belongs stating that the resident cannot afford to pay for the services at the facility. One participant argues:

> Persons with disabilities like me get health services at health centers for free by either bringing a letter from the National Association or from the Wereda of residence explaining that the person has no income and could not pay. But the problem is when I face complex sickness when the health facility refers me to a Hospital. At that time the person is hard of getting services because of the large number of people waiting for the same thing.(Male ,Physically Impaired).

A health practitioner from Guto Meda Health Center confirms that residents who are poor and get a monthly income of less than 250 birr are screened and sent to the health center to be admitted to get health care services free of charge and the Wereda have a budget to pay to the health center. He explained it in his own words as:

> For those who are poor, each Woreda screens residents of their level of monthly income and people who earn less than 250 birr per month can get free

> health care services at health centers and the respective Woreda pay the money for these people to the Health Center.(Male, Health Officer).

While getting treatment may be for free for people with disabilities, cost of transport to the health centre remains a problem especially to those who are unemployed either because of lack of education or the type of impairment they suffer or other reasons.

4.2.5. Absence of Accessible Health Information

Health education is an important tool in transferring knowledge and skills of prevention from diseases. Any strategy for the prevention of the disease is directly or indirectly correlated to information obtained through education. However, the amount of knowledge acquired is determined by the socio-economic context, educational status and the available health services for the people (Ngawana et al, 2002:19).

It is very unlikely that disabled persons get these opportunities accordingly. The high illiteracy level they are in has great influence in hampering their access to relevant prevention mechanisms. The available health educations in the schools and community may not reach persons with disabilities in accessible form. In other words, Persons with disabilities in special schools do not get the same sex educations those in ‘normal’ schools. Likewise, there is no health education related to reproductive health addressing Persons with Disabilities in particular. Above all, the dramas and theoretical practices designed or knowledge promotion on disease prevention systematically excludes Persons with disabilities (UNESCO, 2000).

Respondents who are blind reported that the only way that they can access health information is via listening as one respondent indicates:“I have low understanding on health issues and the only source that I get is through Radio Programs that I listen. I learned about HIV/AIDS as a sole source of information.” Another participant also indicated that “Health promotional activities are ignorant of persons like me with visual impairment since most of their contents are visual. I am unable to learn how to use condom. I have to access it in brail”.

It could be argued that it is not easy to get recent and updated health information in brail for those who learned reading in Braille.

But they emphasized that persons with disabilities need to know more about diseases and their prevention since they are more exposed because of the disabilities than others without disabilities as illustrated below:

> Persons with disabilities should know about their sanitation, nutrition and medication more than people without disabilities because they are prone to diseases because of their disabilities or their low access to information about these important things. (Male, Blind).

The absence of accessible information is also the very concerns of persons with hearing impairments as a respondent who is deaf reported:

> I usually face lack of information on health and related issues. This is because the media is inaccessible for me. I only read and see. This is also the only way to communicate with my Doctor when I regularly visit a health facility for pregnancy check up. I speak to him and he gave me his questions in writing. In addition to this, I read the limps of people while they speak. (Female, Deaf).

The majority of people with impairments reported that there is also a lack of information regarding HIV/AIDS and they were more vulnerable to contracting HIV/AIDS. The following excerpt from the focus group is illustrative:

> Health issues where people with disabilities are left out is the area of HIV/AIDS, we get information about HIV/AIDS awareness through television but not all of us can listen to what is being said on news, for example, people with hearing impairments. People with visual impairments cannot read if the condom has expired because the information is not written in Braille that we can read.(Female, Deaf).

All of the focus group discussants also confirmed that persons with hearing impairments are in a problem of getting the necessary information in writing and getting updated information in an accessible way is not possible which makes persons with disabilities more vulnerable to infections.

4.3 Process Barriers to Health Service Delivery

According to Kroll, Jones, Kehn &Neri (2006) and Hwang et al. (2009) process barriers refer to difficulties experienced by people in the course of service delivery. Examples of such difficulties include convenience of care, receipt of preventive teaching, and aspects of communication between providers and consumers. Here we consider the experiences of people living with disabilities with regard to: language and health provider attitudes, provider knowledge, drugs and medicine, physical access and rehabilitation.

Fiedler (1981) found that among the factors that affect access and utilization are the hours that the care is available. Because service hours are determined by providers and not patients, the most convenient time for patients to obtain care may be very different from the time that is acceptable to providers. Under this section, three major process barriers identified by this study are discussed below.

4.3.1. Health Provider Knowledge and Attitudes

In a study by Becker et al (1997) women described providers as insensitive or lacking awareness of disability issues as they impact reproductive health care. Veltman et al. (2001) found that many patients felt they had unmet primary healthcare needs because their family doctors lacked education regarding persons with impairments. Health care service providers, families and society as a whole do not understand or know much about persons with disabilities.

Some health care providers’ attitudes at some facilities are said to be unbearable. As focus group discussants reported providers at some health facilities, either unconsciously or consciously, treat certain groups of people in society differently from other patients. “In some places patients say that nurses are rude, they insult patients and do not observe privacy as they are supposed to but this does not exclusively apply to people living with disabilities.”

Other health care users complained about the attitudes of the nurses by saying “The attitude of the few nurses from the health centers is bad. They do not even greet patients. The male nurse cannot even put on his uniform; he just works like a doctor”. Another participant reported that “You would stop coming at the health centre and rather use traditional health care to avoid insults from nurses.”

Those who have impairments within societies find it hard to have their health care needs taken care of because those who are supposed to take care of them do not understand their problems. Neri and Kroll (2003) found that relationships with family and friends had been affected because of not getting access to needed primary care services or durable medical equipment. The WHO and WB (2011) concluded that generally, a better knowledge base is required on the prevalence, nature, and extent of disability - both at a national level where policies are designed and implemented, but also at global level with changes monitored over time.

Almost all of the participants thought that health providers have negative attitudes towards people with impairments and deliberately distinguish between real and non-real (i.e. disability) health problems as one respondent states:“It’s difficult to continue asking a question when nurses already think it’s a disability problem instead of a real health problem although it’s something that happens to everyone.”Another respondent complained that health care providers do not practice privacy. “The health workers insult us when we don’t come to the health facility on given dates. They have no idea about our problems to come to the health facilities.”

Participants reported that health professionals have low understanding about disability issues. They are not aware that persons with disabilities have potentials like others to do everything except that their disability prevents them to do. They even consider persons with disabilities as sexually inactive as one respondent marked:

> Health professionals consider persons with disabilities as not sexually active like the other population but we have all the senses except that are damaged by the disability. A blind person cannot see but have all organs functioning very well. A person who is deaf can do everything except that he/she cannot listen. The same is true for other kinds of disabilities.(Male, Physically Impaired).

However, some participants of people living with disabilities praise health workers for their skills. “The nurse is qualified and well trained together with HIV counselors they were trained to do their work. Although she is a well-qualified nurse, she is not friendly.”

Health care service providers themselves confirmed that they have no training concerned with disability issues and especially on how to treat persons with disabilities.

> I do not remember anything from the courses that I took concerning the care giving process for persons with disabilities but I feel that it is the most important issue that needs urgent response from the government to improve the service given to this section of the population. Most of the staffs are fresh and need such vital trainings and education.(Female, Clinical Nurse).

Another health professional recommends, “The educational curriculum for health professional should include disability education. Health Professionals should learn and practice on how to treat persons with disabilities.”

It was surprising to know that most providers are not aware of the disability policy in the Country and what it says about those with disabilities. One provider explains “I know nothing about the policy, but I do have knowledge about disabilities. We do handle them and support them like other people.”

4.3.2. Communication Barriers

It was consistently reported that disabled patients needed more of the health care provider’s time than non-disabled counterparts. The explanation for this included physical, communication and cognitive aspects of disability. In terms of physical factors, disabled patients were often slower in their movements, taking more time to dress and undress themselves, requiring more time for the provider to position and examine them, and taking longer to enter and leave the office. Physicians noted a need to physically rearrange office space before and after an office visit from a patient with physical disabilities.

Communication with disabled patients was also noted to be more time intensive for several reasons. Depending on the disability, patients might experience problems causing to communicate more slowly, or they might use technological aids, slowing the process.

Health service providers noted that they tended to question the patient with a disability in a different way – they asked more probing questions and gave more attention to circumstances of the complaint and whether the service provider and patient had understood each other accurately. When family members or care givers attended appointments, three-way conversations were more time-consuming as one provider reported “Persons with disabilities need more time to treat them very well. They want you to listen them very curiously. But they are also committed to listen in the care giving process than others.”

Patients with a hearing disability required either more detailed or simplified instructions or explanations. Some also required written material to support verbal directives. One of the respondents from the service users confirms the above idea:

> When I visit health facilities the only and important way for communication is through writing on a paper what I am feeling. But there are times when I fail to get what I want because people working there refuse to reply by writing. Some people do not want to write because either they are busy or they are illiterate like the security personnel.(Male, Blind).

One particular individual who had problems with hearing at the time gave his story of how he found it difficult to get treatment because he could not communicate with the providers who do not know sign language.

> The problem again is when coming to the health facility, there are no interpreters and the communication with the doctor was difficult. Sometimes the doctor will not get what you are saying and may end up not treating you as well as it should be and may even prescribe you wrong medications.(Female, Deaf).

One respondent in the focus group gave a solution by saying “The issue of interpretation for people with hearing impairments should be addressed by the government. Courses in sign language should be given because this problem does not only occur at health facilities but also in the public service.”

One health officer in the Sub City made it clear that hearing impaired people are difficult to treat because there are no providers at the health center who can do sign language.

> People who are difficult are the physically impaired people. For example, if he is a sign language patient (mute) and no one can translate what he is talking about, you will find that he might get different medication than the one that is suitable for his illness.(Female, Health Officer).

The other person working in the health facility also added “I treated physically impaired persons such as mentally challenged and deaf people but experienced a problem when it comes to interpretation” The other health care provider also mentioned her concern while persons who cannot speak and hear are admitted to the facility “I am worried when a patient with a hearing disability is admitted. I fear so much because I cannot communicate with sign language. The only option is through writing and using the assistants if any.”

4.3.3. Quality of Health Services

The fundamental goals of a health care system includes improving health outcome and responding to the legitimate expectations of the clients and health care providers, it requires adequate resources, which are not just financial, but also trained staff, appropriate facilities, equipment and pharmaceuticals. Quality of health care is easily defined as doing the right thing, at the right time, in the right way, to achieve the best possible results. Quality of health service aspect is important in measuring barriers to access health care services because, for example, if a health center does not have enough providers, the quality is compromised as this means the health service user will not be able to get treatment when they need it. Some people have to travel long distances from their catchment area. Sometimes this means the health service user will have to wait until they have enough financial resources to be able to move from one health center to another and this then results in not getting the treatment at the right time (WHO,2010).

Low number of providers can affect quality of health care services. In this study, the problem of lack of providers that results in patients not getting treatment when they need it was pointed out by the health service providers and it is reported that in most health centers referrals to hospitals are common as one practitioner working as a counselor indicated “There is still shortage of health care providers in the health care facility. There is no well trained professional in counseling and I am practicing this here because I worked in the same position in other rural parts of the country”.

The other point mentioned by health service providers which related to quality of the health services is that the residents of the community did not accept the services delivered at health centers. They have overlooked the services as described by a health care provider “People do not come to this health center because they think that the health officers and nurses are fresh and they do not know. I believe that even if the services are not at a high standard, we provide quality primary health care.”

Participants repeatedly reported that they do not get services they want at health centers and they don’t believe that there is quality service at health centers. One of the respondents who were with hearing impairments wants diagnosis on the problems of his ear but he reported that the service is not available.

> One of the biggest challenges of accessing primary health care for me is inability to pay for quality services in private clinics. The service is better there but they ask more money. The problem with health centers is the low quality for treating persons with disabilities. The services that I want are not available. For example I want to know what happened to my ear but they cannot do this. (Male, Blind).

Participants from the health centers also admitted that there are shortages of human resources and drugs as a health officer indicates “In this health center, most of the services are referred to hospitals in the city because of the absence of the services here.”In terms of availability of the health centers themselves the researcher confirmed that there are ten health centers in ten Weredas of the sub city. Each of the Wereda residents at least can access one health center in the Wereda. Most of the participants admitted that the services are improving now days even if they are not accessible “Now a days the service provision is being improved than it had been long ago but the accessibility issue is at the same point as before. Buildings are designed without considering persons who use crunches and wheelchairs.”

It can be argued that the dissatisfaction by the barriers of the services by itself is one of the indicators of low quality health care services. This is because the quality of any service is primarily measured by the satisfaction obtained by service users.

4.4 Good Practices

The research found out that with the presence of the above barriers for accessing primary health care services for persons with visual, hearing and physical impairments, there are few good practices identified both in the community and health centers that help persons with disabilities access services better. Participants of the in-depth interview confirmed that people are sympathetic to support persons with disabilities to reach health centers as indicated

> People in the community are so caring for the blind. People asked me always in the street and guide me to a place I want. One person in the health center who is working there asked me to pay for me. I told him that I can pay and I thanked him. The man who treats traditionally also did not receive any money from persons who are blind.(Female, Blind).

Another participant also added that "people are so cooperative and supportive and until now I do not get it difficult to find people from around me to take me to a place I want to go."

All of the health providers also confirmed that persons with disabilities should be given priorities when they seek health services and they repeatedly reported that the only difference between health other health care users and persons with disabilities is that they need priority.

Patients who are disabled and those without disablements are both the same in terms of seeking health care services but those who have disabilities should get priority. The attitude of many people from the community and service providers is not good. They consider the disability as a disease.

Surprisingly, the actions taken in Selam health center are very appreciative and should be replicated to other health centers. The providers confirmed that when persons with disabilities are admitted to the health centers, letter "D" is written on their cards so that they could get services before any one before them. All the health professional staff knows the code and they are served based on that. I also read a poster posted in the waiting area which explains that disabled patients are given priority. This health center is also unique in making all the corridors and entrances accessible for wheelchair users. The health center is also the only one where there is a separate toilet for disabled patients and it is made to support people who use wheelchairs and crunches.

4.5 Consequences of the Access Barriers

One of the questions of the study was what kind of psychological, social and economic problems do persons with visual, hearing and physical impairments encountered in their life as a result of the barriers they face and how they cope with the conditions? Based on the findings of this study the barriers to access health care services by persons with disabilities resulted in the following consequences on their lives and health status.

4.5.1 Psycho-Social Crisis

Lack of consistent health-care access has been associated with a higher risk of secondary conditions, especially for people with more severe disabilities ((NRH-CHDR, 2002). Because of their "Thinner margin of health" (Institute of Medicine (IOM), 1991,), the medical, functional, and psychological consequences of not receiving appropriate health care in a timely fashion—and the practical implications for their level of independence and social and economic participation—are often considerably magnified (Coughlin et al., 2002; Neri & Kroll, 2003).

As the discrimination against persons with visual, physical or hearing impairments has a variety of reasons, it has also a variety of adverse effects on the psychological, social and economic well-being of the disabled. Psychologically, they might develop low self-esteem, hopelessness, lack of trust on others and look other members of the society who are non-disabled suspiciously. Most of the respondents confirmed that it is a very degrading situation when we fail to access services because we are disabled as one participant indicated

> The psychological crises we face are countless. I sometimes hate even being created human because the only reason that I cannot access the facilities is

> because I am disabled and it is not my fault since I was disabled when I was four years old by measles.(Female, Physically Disabled).

Because of the inaccessibility of the services they become angry at them and this resulted in degrading themselves because the process is tiresome for them especially if they visit a health facility without assistants:

> I was so angry by the service I got at the health facility that I used last time because the service is not blind friendly. I stand a lot of minutes to get people to tell me where the process starts and when I get that they told me to go to room number 7. I walked here and there because I could not see it. The steps of the building were also so difficult to go up to the rooms for persons like me.(Female, Blind).

4.5.2. Aggravation of Diseases and the Disability itself

The dissatisfaction created because of the barriers reinforces their problems and it becomes difficult to adhere to the medications**.** Even some service users believe that the disability is caused and aggravated by the inaccessible health care services as a respondent put:

> The consequences when facing the barriers are many for persons with disabilities like me. It may add another disease to the patient who went to a health facility seeking health care. When I become angry I lose my appetite which results in the aggravation of the problem that I want to alleviate.(Male, Physically Disabled).

Another respondent also strongly argues that because of the barriers I face while visiting health facilities, my disability status has been deteriorated. She explained the reason in the following way:

> Last year also I fall down from my wheelchair while a person was helping me by pushing the wheelchair. I was admitted and my disabled leg was diagnosed as broken. The Doctors advised me to remove the broken one but I refused to do so. The accident at this time was because of uncomfortable road to use wheelchairs.(Female, Physically Impaired).

Almost all of the participants also thought that persons with disabilities are more exposed to infections and diseases since most of the health care services are not accessible to them. The following excerpt illustrates this point of view:

> Being disabled exposes persons with disabilities for poor sanitation if they are living in a poor environment. The personal and environmental hygiene coupled with disability aggravate infections and diseases. The public toilets are not accessible and comfortable for the disabled.(Male, Blind).

4.5.3. Damage on Patient- Service Provider Relations

Almost all of the focus group discussants also admitted that the barriers to health care make persons with disabilities more unstable when they come to facilities seeking health care as one participant reported:

> Because of the barriers I face I become in conflict with the health care providers. These resulted in low service and in some cases the provider ignores me. I am not satisfied by the service that I got because I expected to be more than what I experienced.(Male, Physically Impaired).

Some of persons with disabilities who are aware of their rights to the health care services ask the administrators and even health care service providers which make them in conflict and their relations with health care providers is damaged because of that as one of the focus group discussants replied:

> Persons like me may ask providers of their rights because I know it is my right to get the services but the providers with low awareness may reject persons with disabilities and the services may not be totally given to those who need them.(Female, Physically Impaired).

4.5.4. Users' Denial of Health Services

Service users who are blind also ignore health care services because of problems related to locate places at facilities as evidences below:

> Recently, I visited a nearby health center and got an appointment for coming again for checking the progress. I refused to go because it is very difficult to locate the places for asking my case. I bought another medicine from the pharmacy and used it by my own.(Female, Blind).

Most of the respondents reported that health centers are not the choices for seeking primary health care. The physical barriers make the services unthinkable for them and they do not even want to try them. This ignorance because of the barriers prevented the users to get services

4.6 Coping Mechanisms

4.6.1. Self-Care and Traditional Medications

Self-care involves the attitudes and techniques by which individual's assume responsibility for maintaining health and treating illness (Bailey, 1987). When all things fail, patients go to look for their own medication somewhere else. This is mostly caused by difficulties of accessing health centers because of unavailability of medication at health facilities and lack of financial resources as evident from a service user "I buy pain killers and other simple medications from the shops. The other focus group discussant reported "Sometimes if there is no medicine at the clinic and we have money then we have to buy the medicine at the shops, otherwise there is nothing we can do if we don't have money."

The other respondents believe in using traditional medications than going to health facilities which are not accessible to them financially and economically as one respondent confirmed "I use traditional health care and self-care because it is easy to access, easy to use and is free. As I am unable to go to the clinic where they demand money I just serve myself." Another focus group discussant also marked:

> I opt to use traditional medicine when I am unable to buy it from pharmacies. This happens especially when the specific prescription is not available in

> public pharmacies. The barriers sometimes upset me not to use modern health care services.(Male, Blind).

Other experiences of accessing health care services were considered in terms of scheduling of appointments and timeliness of services. It seems that appointments are not utilized in scheduling services. Health service consumers are expected to come to health facilities whenever they can and that is what they do.

Most consumers complained about the timeliness of services, their main complaint being queuing and the time it takes for them to get service. Many people with disabilities described the service as bad because of the time spent in queues. Many of those living with disabilities find it difficult to cope especially in hospitals as explained by one respondent "hospitals are always crowded, that is the reason most people stay away from the facility, but I don't have any other choice. I have to come every day if I am seriously sick."

4.7 Discussion of the Findings

The aim of this study was to investigate barriers that the disabled individuals experience in accessing health care services. The identified access barriers to health care services were grouped into two general categories: environmental-architectural barriers and delivery process barriers. Environmental-architectural barriers encompassed issues of physical accessibility, finance or poverty, location and transportation. Process barriers included communication with patients and providers, knowledge and attitude of service providers and inaccessible health related information for persons with disabilities.

The results of the study conducted among individuals representing different forms of impairments indicate that people with impairments continue to face significant barriers to health care access. Consistent with the findings of other research on health care access for people living with impairments, a wide range of barriers were reported (Drainoni et al., 2006).Many of the findings such as lack of inaccessible transportation and inadequate specialized health care providers largely confirm research in other countries like Zimbabwe (Choruma, 2007) and the United States of America (Scheer et al., 2003) among others.

Many of these barriers are necessarily unique to people with impairments and also their consequences tend to be more severe for people with impairments. People in wheelchairs have problems getting over uncomfortable terrain and making their way through narrow health center paths. Someone with a physical disability who does not have a wheelchair but walks to the facility may damage his/her health further.

Because public transportation is not always an option for those who use wheeled mobility devices, access to health care services by people with impairments as well as their ability to participate in their community settings, is not equal to that of the general population (Scheer et al 2003). In the city of Addis Ababa, public transportation is a method of transport used to get to health facilities especially for those who are poor and could not afford to use private ones which was very expensive. As mentioned in the findings section, the public transportations are not disability friendly. This coupled with the low awareness of the transport service providers such as the assistants and drivers, persons with physical impairments face serious difficulties to reach to health facilities especially when they are sick.

Communication problems between the hearing impaired and the providers and lack of toilets for the physically impaired come across as issues of unequal access to health care. As it is found out by this research, people with hearing impairments face challenges of telling their cases to the service provider since there are no people who can use sign language. The only way patients could communicate is via their assistants and this is against the privacy of the participants. If the information is to be told to the patient the only option is in writing. Deaf users of health services also complained of lack of accessible health information. The same is true for people who are blind. They also want health information in the form accessible to them i.e. the braille. These findings have an implication that our health information dissemination and health promotional activities should be inclusive of all Ethiopians as their language of communication.

Kroll et al. (2006) argue that it is of utmost importance that facilities at health centers are user-friendly. This term means that health centers should not make it difficult for one to get treatment and other services that they are looking for there. Hosain & Chaterjee,(1998) argued that where prevention of disability is not possible, the process of development of permanent disability or handicap can be halted by offering appropriate treatment at an early stage. This will in turn reduce the social and economic burden of poor countries where usually an insufficient amount is spent on health and social welfare. The newly constructed buildings for the health centers are negligence of the rights of persons with disabilities. Although a ramp is built to the first floor, most of the services are located above the ramps and the ramps are also sloppy to be used by the users themselves. These are indications that when the buildings are constructed, the rights of persons with physical impairments were not considered.

If the health center did not have sufficient medication (as respondents from service users and reported under quality of care theme) patients had to purchase medication from their own pocket. Many individuals reported that for reasons of cost, they had been unable to access health care services. Poverty lies at the heart of facilitating the barriers of health care services because the ability to pay for services and medication is a critical point for getting treatments when they are needed. Since most people with disabilities are unemployed, dependents on their family, this factor plays a very prominent role.

Many individuals also expressed feelings of frustration and anger resulting from the misunderstandings on the part of some providers. This confirms the process barriers, specifically attitude and communication barriers that this study aimed to investigate. As confirmed from both service users and providers, the staffs of health centers are not capable of handling persons with disabilities and some of them even misunderstand them as incapable and dependents. The researcher believes that this is not surprising because in the community there is a deep rooted bad attitude towards person with disabilities as dependents and beggars and the cause of the disability as a sin from God. The health care providers also come from the community and if they are not trained on this area they may have the same attitudes.

According to Fitzpatrick, Powe, Cooper, Ives, & Robbins (2004), perceptions of providers' attitudes toward a patient's health and personal needs, as perhaps measured by time spent with a patient and level of response to concerns, may also act as a barrier to obtaining necessary treatment and preventive care which then forms part of the process barriers. The researcher is of the opinion that much focus on the competencies of health professionals is necessary for them to improve the services. Health professionals need special trainings on handling disabled persons.

The researcher also strongly believes that the experiences surrounding access to health care as reported by the respondents can reasonably be promulgated to experiences of people with disabilities who did not form part of the study in other sub cities of Addis Ababa and more aggravated in the other parts of Ethiopia where availability and accessibility are lower. However, despite the severity of the barriers faced in Gulele sub city understudy, it is believed that individuals with impairments in other parts of the country may face even greater challenges than those reported here, in view of the highly dispersed population found in Ethiopia where people are dispersed far from established towns/homelands and towns are also far away from one another. There is necessity to study the barriers one by one for planning specific interventions.

Some individuals felt excluded in decision-making because their needs and wants were not met. For some people, the type of attitude and lack of respect they received from providers kept them away, although they did not find any difficulty reaching the facility. Many respondents coped with barriers either by buying their own medications, making their own form of transportation when there was none or going to traditional healers as a way to get treatment. The denial of modern health facilities at the local level has a very bad implication because it is a sign for ignorance of the rights of a significant amount of the general public. The barriers also resulted in psychological crisis and also it aggravates the health status of persons with disabilities.

With the presence of the barriers discussed above, there are also very good beginnings at very few health facilities under this research but the success should be praised and be the model for others who lack even ideas to improve the services. Health centers which ignore the a significant section of the population by no means does not have quality health services since satisfaction of clients is at the center of quality health care services.

Chapter Five

Conclusion, Recommendation and Implications for Social Work Practice

5.1 Conclusion

While a small exploratory study is hardly definitive, the results of this study identify and classify barriers faced by people with disabilities when they attempt to access health services. Hopefully, future research will include people with disabilities as an integral part of research team in addressing these issues.

In addition to the existing challenges to address all the problems faced by people with disabilities in accessing health services, given limited resources and spiraling health-care costs, it is also not clear whether the current working system in the ground is the best one in the long run given the barriers discussed in this study.

Lack of awareness among the general public, policy makers, engineers and health professionals is one of the biggest obstacles and the sources for the barriers created at different levels. It could be argued that, still now, a significant number of people misunderstood disability in Addis Ababa as well as in the countryside.

The researcher believes that to eliminate access barriers and meet the needs of people with different impairments in an effective and sustainable way, there should be innovative thinking and input from those intimately familiar with and affected by current barriers. It also requires input from health service providers who are familiar with the structural processes and environmental challenges of providing accessible and high quality service to members of this group.

The barriers of accessing primary health care services has a number of negative impacts on psychological, social and economic well-being of the individual concerned and his/her family and the society as well. They become suspicious; consider themselves as inferior to others, develop hopelessness, low self-esteem, etc as a result of the discrimination made against them. As a result, they totally leave visiting health facilities which may also aggravate their problem and living conditions.

5.2 Recommendations

Based on the present findings and analysis, the following recommendations are forwarded to improve health service access for persons with physical impairments.

Various forms of awareness raising programs should be extended through mass media, workshops, counseling, etc. Both electronic media and press are appropriate instruments since they can address a number of people throughout the country. Associations of PwDs can also prepare their publications and utilize them to raise awareness of the public and health service providers about the rights, needs, abilities and potentials of PwDs. Workshops and counseling services should be organized and conducted by concerned bodies to those who need the programs. In all forms of the programs, the target populations that need to be addressed include: government officials of various sectors and at various levels, health staffs from the government, non-government and private sectors, and other citizens with disabilities and the general public at large. All of the programs should aim at raising the awareness of the people and sensitizing the target population about the rights, needs, abilities and potentials of PwDs.

Interventions should also be directed at enhancing health service providers' understanding of how to work effectively with people with physical impairments. For example, providers should be able to determine real health issues from disability issues. I, the researcher, strongly recommend that the disability education should also be part of the education system especially to all professionals whose work is related to health service delivery.

Linking of rehabilitation specialists, as consultants, to group practices or community health should be done so that the specialists' expertise would be available to primary health service providers in community settings.

To date, the sub city administration has built health centers, provided health services and medications, and also has introduced free access to health care services for poor people with disabilities and a lot more but there are still those critical problems related to the needs of those with physical impairments that the administration need to consider. The provision of trained sign language interpreters or training health care providers, accessible physical infrastructure for people in wheel chairs, constructing more health centers in communities for those who cannot walk etc should get a prime attention.

Curbing the challenges of quality and accessible health service provision to persons with impairments is imperative as a matter of equity. This study hopefully will motivate health professionals to go beyond the minimum requirements set by law in order to make facilities and services usable to disabled patients as much as possible. By meeting the needs of people with impairments, one will also be providing enhanced facilities and services to other health care beneficiaries because people with impairments are frequent users of health care services and will provide a good measure of the overall performance of the health care system.

Finally, this research can be used as an input for further social work studies on each of the barriers identified since the barriers are created by many stakeholders working with health centers of the sub city under this research. And it can also be replicated to other sub cities and throughout the country as well to study and further investigate the severity of the barriers at different levels.

5.3 Implications for Social Work Practice

The research finding has a lot of implications for all relevant stakeholders to alleviate the barriers of accessing primary health care services for persons with disabilities. First of all, the result calls for social work interventions to address the special needs of the disabled people. Here, it is the role of the social worker in lobbying and advocacy of the rights of this significant section of the population to get the necessary basic rights to primary health at health centers in their localities.

Social workers should also be the facilitators of the awareness creation campaigns recommended under this research to the general public since most of the barriers are created by the misunderstandings of people towards persons with different kinds of disabilities.

Empowerment of persons with disabilities to economic resources has a great role to eliminate barriers related to the cost of services and medications. Social workers should work hard to empower people to know their rights and capabilities since it plays an important role in struggling to empower themselves. Coordinating the different activities of the government and civil society organizations on empowerment of them should be done by social workers.

Social workers are necessary at health centers for critically identifying and following up of health care demands and priorities on a regular basis. They have to closely work with health administrators to suggest solutions for the existing health care access barriers.

In addition, social worker could do sensitization for disability associations and organizations in the city. They should also strive for making network among the national social welfare institution, national and regional disability policy makers and disability associations and non-governmental organizations in the sub- city. Moreover, it should be the task of social workers to follow up the implementation of policy plans at the grass root level. This, of course, could be done after the inclusion of PWDs in health care programs of the concerned parties mentioned above.

The above programmes need to incorporate local community members, community social workers, traditional associations (Edir, *Mahiber, and Equb*), and school teachers, religious and traditional leaders. The networks within these local people make the implementation of the programs possible. This is because disability as shown in literature section is more of social construction rather than disease. If PwDs and the public are understood by these people, provision of primary health care services will not be difficult.

With regard to direct access to health related information, social workers should deal with government and non-government organizations and in the production of materials in accessible formats. These include braille scripts for the blind, wheel chairs and orthopedic materials for physically disabled and provision of professional training for sign language interpreters for the deaf. Moreover, health professionals particularly those working in the delivery of health services at health centers should be given sign language training by special needs professionals.

On top of these, there need to be a comprehensive research on the prevalence of the infection rate at the national level. Social worker has to supplement the practical interventions with relevant applied research on accessibility of health care services for persons with disabilities. Further social work research on each of the barriers identified is also one area of social work interventions since the barriers are created by many stakeholders working with the health centers of the sub city. The research can also be replicated to other sub cities and throughout the country to know the severity of the barriers at different levels.

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APPENDICES

Appendix 1: Informed Consent Form (English)

I am a student pursuing a Masters degree in Social Work. I am inviting you to participate in a study that will examine the barriers to accessing primary health care services for persons with disabilities in Gulele sub city. The information gathered through this study will be reported in my thesis.

Persons with visual, hearing and physical impairments, Health officers and Nurses working in Gulele Sub City of Addis Ababa city Administration and who lived more than six months in the sub city will be recruited for this study. There is no intended monetary compensation involved for participating in this study. The potential reward of knowing that the participant has contributed to a knowledge base that will help persons with disabilities receiving health care services in the future is the only benefit.

Confidentiality of the participants will be protected. I will be the only person to receive your consent form and gather your information included in the study for the "findings" part of my thesis. A brief excerpt from individuals' answers to the open-ended questions may be included in this thesis, but these excerpts will be strictly anonymous.

Although your input would be greatly appreciated, your participation in this study is absolutely voluntary. You may withdraw from this study at any point in time when you believe to do so.

Sign Below for your Confirmation

Thank you for participating in this study.

______________________________________ __________________

(Name) (Date)

Kemal Seid (Kemalseid60@yahoo.com)

Appendix 2: Informed Consent Form (Amharic)

የመተማመኛ ቅጽ

እኔ የሶሻል ወርክ የማስተርስ ተማሪ ነኝ፡፡ በጉለሌ ክፍለ ከተማ መሰረታዊ የጤና አገልግሎቶች የተደራሽነት መሰናክሎችን ለአካል ጉዳተኞች በሚዳስስ በዚህ ጥናት ትሳተፉ ዘንድ ተጋብዛችኋል፡፡ በጥናቱ የሚሰበሰበው መረጃ በጥናቱ ውስጥ ብቻ የሚካተት ይሆናል፡፡

የዚህ ጥናት ተሳታፊዎች ማየት የተሳናቸው፣መስማት የተሳናቸው፣አካላዊ ጉዳት ያለባቸው፣የጤና መኮንኖች ነርሶች፣ ሲሆኑ በጉለሌ ክፍለ ከተማ ቢያንስ 6 ወራት የኖሩ መሆን አለባቸው፡፡በዚህ ጥናት በመሳተፍ የሚገኝ ገንዘብ የለም፡፡ በጥናቱ በመሳተፍ ሊገኝ የሚችለው ብቸኛ ጥቅም አካል ጉዳተኞች ተደራሽ የጤና አገልግሎት እንዲያገኙ ለማድረግ የሚያስችል ተጨማሪ ዕውቀት ማበርከት ነው፡፡

ተሳታፊዎች የሚሰጡት ግላዊ መረጃ በሚስጥር የሚያዝ ይሆናል፡፡የርሰዎን ፈቃድ የምወስደውና መረጃ የምሰበስበው እኔ ብቻ ስሆን መረጃው በጥናቱ ግኝቶች ውስጥ የሚካተት ይሆናል፡፡ ግልጽ ሃሳቦች ከሰጧቸው መልሶች በጥናቱ የሚካተቱ ቢሆንም መረጃውን የሰጠው ሰው ስም በፍጹም አይጠቀስም፡፡

እርስዎ የሚሰጡት መረጃ በጣም ጠቃሚ ቢሆንም በጥናቱ መሳተፍ በርስዎ ሙሉ ፍላጎት ላይ የተመሰረተ ነው፡፡ እርስዎ ባመኑበት ጊዜ ራስዎን ከጥናቱ ማግለል ይችላሉ፡፡

ከዚህ በታች በመፈረም ፈቃደኛ መሆንዎትን ያረጋግጡ፡፡

ለመሳተፍ ስለወሰኑ አመሰግናለሁ!!

____ ____________________

(ስም) (ቀን)

Kemal Seid (Kemalseid60@yahoo.com)

Appendix 3: Interview guide with health care providers (English)

Health Center__________________
Occupation__________________
Date of interview______________________
Socio-Demographic information

1. **Gender ______________**
2. **Year of Service _________**
3. **Age __________________**
4. **Educational Level________**

Guiding Questions

1. Could you explain your understanding of equitable health care access?
2. What factors according to you increase people's vulnerability to poor health care access / which patients struggle to access the services at the facility?
3. How accessible is the facility where you work for patients (physical, costs, time, type of services, equipment, number of health care workers)
4. Tell me about how patients are treated in general in the facility (fairness, equality, respectfully, patiently)
5. Can you tell me about your experiences (stories & examples) of providing health services at this facility (Have there been situations/ people/ cases that have been particularly challenging/ difficult/ positive/ successful?) Can you give an example of patients that are easy to treat and others that are difficult?
6. How do you understand disability?
7. Have you any experience of treating people with disabilities? Probe: Could you tell me about that? (Physical, visual or hearing) (Do you find them more challenging than other patients?)
8. Do you remember from your study about how to treat persons with different disabilities?
9. Do you think that health service providers in the health facility you work with have good understanding about disability? Why?

10. What do you think are the major barriers for persons with disabilities for accessing health care services?
11. In your opinion what should be done to improve the health care services to be more accessible for persons with disabilities?
12. How satisfied are you with your job and the service you deliver?
13. Could you tell me any challenges in this facility that prevents you from performing your duties as you would like to perform them?
14. Anything you want to add before we conclude our discussion

Thank you so much for committing your time for participating in this research!!!

Appendix 4: Interview guide with health care providers (Amharic)

ለጤና ባለሙያዎች የተዘጋጀ የመጠይቅ

የስራ መደብ______________________________

የአገልግሎት ዘመን ______________________________

መጠይቁ የተካሄደበት ቦታ __________________________

ቀን__________________________

የግል መረጃዎች

1. ጾታ__________
2. እድሜ_______________
3. የትምህርትደረጃ ______________

ጥያቄዎች

1. እርሰዎ ፍትሃዊ የሆነ ተደራሽ የጤና አገልግሎትን እንዴት እንዴሚረዱት ቢነግሩኝ?
2. በርስዎ አመለካከት ሰዎች ደካማና ተደራሽ ያልሆነ የጤና አገልግሎት እንዲያገኙ የሚያደርጉ ነገሮች ምን ምን ናቸው? እርስዎ የሚሰሩበትን ተቋም እንዴ ምሳሌ በመውሰድ
3. እርሰዎ በሚሰሩበት ተቋም ከአካላዊ (ፊዚካል)፣ወጪ፣ አገልግሎት፣ባለሙያዎች ፣ የህክምና መሳሪያዎች አንጻር ለታካሚዎች ምን ያህል ተደራሽ ነው?
4. በጤና ጣቢያው ህሙማን እንዴት እንዴሚሰተናገዱ ቢያስረዱኝ? (እኩልነት፣ ፍትሃዊነት፣ማከበር፣ትዕግስት)
5. የጤና ባለሙያ ሆነው ሲሰሩ ካጋጠሚቸው አስቸጋሪ ወይም ውጤታማ ከሆኑ አጋጣሚዎች ቢያካፍሉኝ? ለማከም በጣም ቀላል ወይም አስቸጋሪ ከሆኑ ታካሚዎች ምሳሌ ቢሰጡኝ?
6. አካል ጉዳተኝነትን እንደት ይረዱታል?
7. የአካል ጉዳት ያለባቸውን ሰዎች የማከም አጋጣሚ ነበረዎት? ስለዚያ በዝርዝር ቢያስረዱኝ? ከሌሎች ሰዎች አስቸጋሪ ሆነው አገኙአቸው?

8. ከተማሩት ትምህርት የአካል ጉዳት ያለባቸውን ሰዎች እንዴት ማስተናገድ እንደሚገባ የሚስታውሱት ነገር አለ?
9. በርስዎ አስተያየት የስራ ባልደረባዎችዎ ስለአካልጉዳተኞች በቂ ግንዛቤ አላቸው ብለው ያምናሉ? ለምን?
10. በእርሰዎ እምነት የአካልጉዳት ያለባቸው ሰዎች የጤና አገልግሎቶችን ተደራች በሆነ መልኩ እንዳያገኙ የሚያደርጉ መሰናክሎች ምንምን ናቸው?
11. በርስዎ አስተያየት የአካል ጉዳት ያለባቸው ሰዎች የጤና አገልግሎቶችን ተደራች በሆነ መልኩ እንዲያገኙ ምንምን ዕርምጃዎች መወሰድ አለባቸው?
12. በስራዎና በሚሰጡት አገልግሎት ምን ያሕል ይረካሉ? ለምን?
13. በዚህ ጤና ጣቢያ ስራዎችን በፈለጉት መንገድ እንዳይሰሩ የሚያደርግዎት አስቸጋሪ ፈተናዎች አሉን?
14. ውይይታችንን ከማጠቃለላችን በፊት መጨመር የሚፈልጉት ነገር ካለ?

ጊዜዎትን ወስደው በጥናቱ በመሳተፍዎ በጣም አመሰግናለሁ!!!

Appendix 5: Interview guide with health care Users (English)

Participant ________________________________

Study site _________________________________

Date of interview______________________

Socio-Demographic information

1. Gender ____________
2. Age Group___________
3. Educational Status______
4. Current Employment Status__________
5. Income range family _____________
6. Based on impairment (physically, hearing, visual) can you tell me about your impairment-what happened to you and how did you become impaired? (ask about types of activities that are difficult for the person to do in addition to their classification of their disability type)

Guiding Questions

1. Can you tell me your understanding of health and health related issues?

- ✓ Hygiene
- ✓ Nutrition
- ✓ Medication
- ✓ Training
- ✓ Related to the disability

2. What are your health needs?

- ✓ - Hygiene
- ✓ - Nutrition
- ✓ - Medication
- ✓ - Training

3. Do you access health care in the same way as everyone else?

a) In your family b) in your community?

4. What factors/problems according to you make it more difficult for a person to access health care (vulnerability factors) and how?

5. Do you experience any of the above factors? If yes, could you explain (with examples) and also to relate how this affects your health care access.

6. Tell me about your general health status. How would you describe your health today- excellent, good, poor, very poor?

7. Please discuss your use of health care services and experiences while accessing these in the past six months (or further back if they want, but focus on past six months) Why did you need health care? What services did you access and receive?

8. How did you experience the service? Was it 1) excellent 2) good 3)neither good nor bad 4) bad 5) very bad With Regard to:

- ✓ Making and getting an appointment
- ✓ Convenience of the services hours
- ✓ The physical surroundings
- ✓ Accessibility
- ✓ Crowding, availability of seats, water and other refreshments, restrooms, cleanliness
- ✓ Registration procedures
- ✓ Security
- ✓ Privacy
- ✓ Status
- ✓ Status of the equipment
- ✓ Availability of your medical records
- ✓ Number of staff
- ✓ Attitude of staff
- ✓ Support received when needed
- ✓ Skills of staff
- ✓ Waiting times

9. Were you satisfied with the service? Why / why not?

10. How did the care impact on your health status and quality of life? Did you feel better after the health care?

11. Tell me about any other obstacles you face when you are seeking health care/accessing health services?

12. What mode of transport do you use to get to the health care facility? What challenges you faced?

13. How do you see the Cost of health care and other costs? Are they acceptable to pay for you?

14. What consequences the barriers resulted on the users of services? What strategies you use to get out of the challenges?

15. Do you have any ideas on how these challenges can be addressed?

Additional questions adapting to the three impairments

1. Tell me about the physical accessibility of the point of service delivery, toilets examination rooms, pharmacy, special investigations etc.(for physically impaired?

2.Was information / explanations on procedures, your condition, and medication given in an adequate, understandable way? Could you manage to get sign language interpreters? (For persons with hearing impairments).

3. Did you face any difficulty to communicate with supportive and medical staff? If so what was the reason?(for all impairments)

4. Did you get help from someone when you want to go to a health post? if not why?

5. Is there any idea that you want to add before we close our discussion?

Thank you so much for committing your time for participating in this research!!

Appendix 6: Interview guide with health care Users (Amharic)

ለጤና አገልግሎት ተጠቃሚዎች የተዘጋጀ መጠይቅ

መጠይቁ የተካሔደበት ቦታ______________

ቀን________________

የግልመረጃዎች

1. ፆታ_____________

2. የዕድሜክልል_______________

3. የትምህርትደረጃ______________

4. የስራ ሁኔታ_________________

5. የቤተሰብየገቢመጠን_____________

የቃለ መጠይቅ መነሻ ጥያቄዎች

1. ስለ እርሰዎ የአካልጉዳት እስኪ ትንሽ ያጫውቱኝ? ለመሆኑ የአካልጉዳቱ እንደትተከሰተ? በአካል ጉዳቱ ምክንያት መስራት የማይችሏቸው ነገሮች ምንድን ናቸው?

2. ጤናና ተያያዥ ጉዳዮችን በተመለከተ ያለዎት ግንዛቤ ምን ይመስላል? ለምሳሌ፡

✓ ንጽህና
✓ አመጋገብ
✓ ህክምና/መድሃኒት
✓ ስልጠና
✓ ከአካልጉዳትጋርያላቸውግንኙነት

3. እርስዎ ምን ምን መሰረታዊ የጤና ፍላጎቶች አለዎት?

✓ ንጽህና
✓ አመጋገብ
✓ ህክምና/መድሃኒት
✓ ስልጠና

3. እርሰዎ በቤተሰብዎ ወይም በሚኖሩበት ማህበርሰብ ከሌላው ሰው እኩል የጤና አገልግሎት ያገኛሉ?

4.በርስዎ አስተያየት አንድን ሰው የጤና አገልግሎት በተገቢው ሁኔታ ተደራሽ በሆነ መልኩ እንዳያገኝ የሚያደርጉት ነገሮች ምንምን ናቸው? እንዴት?

5.እርሰዎከላይየጠቀሷቸውችግሮችአጋጥሞዎትያውቃል?እስቲበዝርዝርያጫውቱኝ?ያጋጠመዎትእንቅፋትየጤናአገልግሎቱንእንዳያገኙአድርጎዎታል?

6. የርሰዎንየጤናሁኔታእንዴትያዩታል?

7. እስቲ ባለፉት 6 ወራት የተጠቀሙትን የጤና አገልግሎት ያጫውቱኝ? የጤና አገልግሎቱን ለምን ፈለጉት? ምንምን አገልግሎቶችን አገኙ?

8. አገልግሎቱን እንዴት አገኙት? ከሚከተሉትን ነገሮች አንጻር ያገኙት አገልግሎት እ.በ.ጥሩ ፣ በጣም ጥሩ ወይስ ጥሩ ያልሆን? በቀጠሮ መስተናገድ

- ✓ የአገልግሎት ጊዜ ምቹነት
- ✓ የአካባቢው ሁኔታ
- ✓ ተደራሽነት
- ✓ ወረፋ፣ ንጽህና፣ ማረፊያ ቦታው
- ✓ የምዝገባ ሁኔታው
- ✓ ደህንነት
- ✓ ግላዊነት
- ✓ ደረጃ
- ✓ የመሳሪያዎች ሁኔታ
- ✓ የግል መረጃ ማግኜት
- ✓ የሰራተኛ ብዛት
- ✓ የሰራተኞች አመለካከት
- ✓ እገዛ ሲፈልጉ ማግኘት
- ✓ የባለሙያዎች ብቃት

9. በአገልግሎቱ ረክተው ነበር? ለምን ?

10. ያገኙት አገልግሎት በጤናዎና በህይወትዎ ላይ ምን ተጽኖ ነበረው? ከአገልግሎቱ በኋላ የተሻለ የጤና ስሜት ተሰማዎት?

11. የጤና አገልግሎት ለማግኘት ሲፈልጉ እንቅፋት የሚሆኑ ሌሎች ነገሮች ምንምን ናቸው?

12. ወዴ ጤና አገልግሎት ሲመጡ የሚጠቀሙት የትራንፖርት አይነት ምንድንነው? ምን ችግሮች አጋጥሞዎታል?

13.ለጤና አገልግሎት የሚወጡ ወጪዎችን እንዴት ያዩታል? ሌሎች ምን ተያያዥ ወጪዎች አሉ? በርስዎ አስተያየት መክፈል የሚቻል ነው?

14.በርሰዎ አስተያየት የጤና አገልግትን ተደራሽ በሆነ መልኩ አለማግኘት በተጠቃሚው ላይ ምንምን ውጤቶቸን ያስከትላል? እንዴትስ መቋቋም ይቻላል?

15. እንቅፋቶቹን ለማስወገድ ምን መሰራት አለበት ይላሉ?

ተጨማሪ ጥያቄዎች እንዴ የ አካል ጉዳቱ እየተጣጣመ የሚጠየቅ

1.ስለጤና ጣቢያው አካላዊ ተደራሽነት-ሽንት ቤት፣ የምርመራ ክፍል፣ ፋርማሲ፣ ምርመራ ወ.ዘ.ተ (ለአካላዊ ጉዳት ላለባቸው)

2.የሚተላለፉ መረጃዎች ለርሰዎ ተደራሽ ናቸውን? የምልክት ቋንቋ የሚስተረጉም ሰው አለ? (መስማት ለተሳናቸው)

3. ሰራተኞች/ የህክምና ባለሙያዎች ጋር ለመግባባት ተቸግረዋል? ምክንያቱ ምንድን ነው?

4. ወዴ ጤና ጣቢያ ለመሄድና አገልግሎት ለማግኘት ያገዘዎት ሰው ነበር? ካልነበር ለምን?

5. አልተነሳም የሚሉት ጉዳይአለ?

ጊዜዎትን ሰጥተው በጥናቱ ስለተሳተፉ በጣም አመሰግናለሁ!!!!

Appendix 7: Guide for Focus Group Discussion with health care Providers (English)

Introduction: Hello, I am Kemal Seid, I came from Addis Ababa University, School Social Work. I am here to open discussion as a group with primary health care service Providers on Barriers of accessing primary health care services for persons with visual, physical and hearing impairments in Gullele Sub city. I would like to ask your opinion of health service barriers, in general. All comments, both positive and negative, are welcome. I would like to assure you that confidentiality for your comments will be respected and will be used only for research purpose. Are you willing to participate in the discussion? I greatly appreciate your taking time to speak with me.

If yes, proceed

If no, thank and stop here.

____

(Signature of interviewer certifying that respondents has given informed consent)

1. Introduction of each member to the group
2. How do you see quality of the services provided by the health center you came from?
3. Do you think that the services of your facility are accessible to all the people including those with physical, hearing and visual impairments? If not why?
4. What barriers do you think prevent people with disabilities from using health services? Could you mention cases?
5. Do you think that supportive and medical staff has misconceptions on disability?
6. In your opinion, what should be done to minimize or eliminate the barriers of accessing health care services for persons with disabilities?
7. Anything you want to add before we conclude?

Many Thanks for committing your time for this important discussion!!

Appendix 8: Guide for Focus Group Discussion with Health Care Providers (Amharic)

ከጤና ባለሙያዎች ጋር ለሚደረግ ውይይት መነሻ ሀሳቦች

መግቢያ፡ ጤና ይስጥልኝ!! ከማል ሰይድ እባላለሁ፡የመጣሁት ከአድስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ት/ቤት ነው፡፡የመጣሁበት ዋና ዓላማ በጉለሌ ክፍል ከተማ በመሰረታዊ የጤና አገልግሎቶችን ለማግኘት በአካል ጉዳተኞች ላይ የሚከሰቱ የተደራሽነት መሰናክሎች ላይ ለመወያየት ነው፡፡ በአጠቃላይ የጤና አገልግሎቶችን ለማግኘት የተደራሽለት መሰናክሎች ላይ ያላቸሁን አስተያየት እንድተገልጹልኝ እጠይቃለሁ፡፡ማንኛውንም አሉታዊም ሆነ አዎንታዊ አስተያየት መስጠት ትችላላቸሁ፡፡የምትሰጡት ግላዊ መረጃ ሚስጥራዊና ለዚህ ጥናት ብቻ እንደሚውል ቃል እገባላችኋለሁ፡፡

በዚህ ውይይት መሳተፍ ትፈልጋላች?

ከተስማሙ እቀጥላለሁ፣ካልተስማሙ አመስግኜ አቋርጣለሁ፡፡

____

(ለመተማመኛው ቅጽ የአጥኚው ፊርማ)

የመነሻ ጥያቄዎች

1. ተሳታፊዎች ራሳቸውን ያስተዋውቃሉ
2. የመጡበትን ጤና ጣቢያ የአገልግሎት ጥራት እንዴት ያዩታል?
3. ጤና ጣቢያው የሚሰጠው አገልግሎት ለሁሉም ሰው፣(መስማትና ማየት የተሳናቸውን፣የአካል ጉዳት ያለባቸውል)ተደራሽ ነው ብለው ያምናሉ?እንዴት?
4. በርሰዎ አስተያየት አካል ጉዳተኞች የጤና አገልግሎቶችን ተደራሽ በሆነ መልኩ እንዳይጠቀሙ የሚያደርጉ መሰናክሎች ምንድን ናቸው?
5. የጤና ባለሙያዎችና ሌሎች ሰራተኞች ስለ አካል ጉዳተኞችን ለማስተናገድ በቂ እውቀትና ችሎታ አላቸውን ?
6. መሠናክሎችን ለማስወገድ በተለያዩ አካላት ምን ምን ርምጃዎች መወሰድ አለባቸው?

Appendix 9: Guide for Focus Group Discussion with health Care Users (English)

Introduction: Hello, I am Kemal Seid, I came from Addis Ababa University, School Social Work. I am here to open discussion as a group with primary health care service users on Barriers of accessing primary health care services for persons with visual, physical and hearing impairments in Gulele Sub city. We would like to ask your opinion of health service barriers, in general. All comments, both positive and negative, are welcome. I would like to assure you that confidentiality for your comments will be respected and will be used only for research purpose. Are you willing to participate in the discussion? I greatly appreciate your taking time to speak with me.

If yes, proceed

If no, thank and stop here.

____

(Signature of interviewer certifying that respondents has given informed consent)

1. Introduction of each member to the group
2. In your opinion, how do you see the primary health care services by health centers in the sub city?
3. Are the services accessible for persons with disabilities like all the other population? discuss barriers for visual, hearing and physical disabilities
4. What are the challenges or barriers of accessing health services in your locality? discuss barriers for visual, hearing and physical disabilities
5. Are health service providers capable enough to treat people with visual, hearing and physical impairments? Could you share us your experiences?
6. What are the possible consequences of the barriers on the users of the services and how they cope with the challenges?
7. What do you recommend for improving accessibility of the services?
8. Any ideas before we conclude?

Appendix 10: Guide for Focus Group Discussion with health care Users (Amharic)

ከጤና አገልግሎት ተጠቃሚዎች ጋር ለሚደረግ ውይይት መነሻ ሀሳቦች

መግቢያ፡ ጤና ይስጥልኝ!! ከማል ሰይድ እባላለሁ፡የመጣሁት ከአድስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ት/ቤት ነው፡፡የመጣሁበት ዋና ዓላማ በጉለሌ ክፍል ከተማ በመሰረታዊ የጤና አገልግሎቶችን ለማግኘት በአካል ጉዳተኞች ላይ የሚከሰቱ የተደራሽነት መሰናክሎች ላይ ለመወያየት ነው፡፡ በአጠቃላይ የጤና አገልግሎቶችን ለማግኘት የተደራሽለት መሰናክሎች ላይ ያላቸሁን አስተያየት እንድተገልጹልኝ እጠይቃለሁ፡፡ማንኛውንም አሉታዊም ሆነ አዎንታዊ አስተያየት መስጠት ትችላላቸሁ፡፡የምትሰጡት ግላዊ መረጃ ሚስጥራዊና ለዚህ ጥናት ብቻ እንደሚውል ቃል እገባላችኋለሁ፡፡

በዚህ ውይይት መሳተፍ ትፈልጋላች?

ከተስማሙ እቀጥላለሁ፣ካልተስማሙ አመስግኜ አቋርጣለሁ፡፡

የመነሻ ጥያቄዎች

1. ተሳታፊዎች ራሳቸውን ያስተዋውቃሉ
2. በርሰዎ አስተያየት በክፍለ ከተማው ባሉ ጤና ጣቢያዎች የሚሰጡ አገልግሎቶችን እንዴት ያዩታል?
3. አገልግሎቶቹ ለአካል ጉዳተኞች ልክ እንዴ ሌላው ማህበረሰብ ተደራሽ ናቸውን?መስማትና ማየት የተሳናቸውን፣የአካል ጉዳት ያለባቸው ላይ በማተኮር እንወያይ?
4. በሚኖሩበት አካባቢ የጤና አገልግሎቶችን ተደራሽ በሆነ መልኩ ለማግኜት ምን ምን መሰናክሎች አሉ? በተለይ መስማትና ማየት ለተሳናቸው፣የአካል ጉዳት ላለባቸው
5. የጤና ባለሙያዎች የአካል ጉዳት ያለባቸውን ሰዎች ለማስተናገድ በቂ ችሎታና እውቀት አላቸውን? ተሞክሮዎትን ቢያጋሩን
6. መሰናክሎቹ በአገልግሎት ተጠቃሚዎች ላይ ምን ምን ተጽኖዎችን ያመጣሉ? እንዴት መቋቋም ይቻላል፡፡
7. የአገልግሎቶቹን ተደራሽነት ለማሻሻል ምን መደረግ አለበት?

Appendix 11: Observation Checklist for

Physical Accessibility of Health Centers for persons with disabilities

Name of the Woreda_____________________________________

Name of the Health Center_________________________________

S.N	**Indicators of Physical Accessibility**	**Notes**	**Remarks**
1	Main Door Entrance to the Health Facility		
2	Availability of Ramps to the Floors of the Building		
3	Situation of the Rest rooms		
4	Condition of the Reception /Waiting Area		
5	Exam Room(door Entrance, height of Tables(Adjustable or not)		
6	Availability of sign language interpreters/Assistants		