HEALTH FACILITIES READINESS TO ACCOMMODATE EXPECTANT WOMEN WITH PHYSICAL DISABILITIES IN SOROTI CITY

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RS/2MO7/014

A DISSERTATION SUBMITTED TO THE FACULTY OF PUBLIC HEALTH, NURSING AND MIDWIFERY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH LEADERSHIP OF UGANDA CHRISTIAN UNIVERSITY

September,2025

UGANDA CHRISTIAN UNIVERSITY

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Declaration

I Aanyu Gorreti declare that I am the author of this dissertation topic and that any assistance I received in its preparation is fully acknowledged and disclosed in. I have also cited sources from which I used data, ideas or words, either quoted directly or paraphrased. I also certify that this dissertation was prepared by me specifically in partial fulfilment for a Master's in Public Health Leadership degree at Uganda Christian University.

Signed.................................... September, 2025

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Supervisor's Approval

This is to certify that the research titled "**health facilities readiness to accommodate physically disabled women in Soroti City**" was done under my supervision and it has been submitted for examination with my approval.

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Rev. Canon Evatt Mugarura

Supervisor

Date: September,2025

Dedication

I dedicate this work to my late parents Mr. And Mrs Olaki Johnston Inangolet and Mrs. Ilingata Angela.

Acknowledgement

I acknowledge the contributions of several individuals and institutions in the design and excursion of this research. Many thanks go to Rev. Canon Evatt Mugarura

, my supervisor and the Lecturers of Uganda Christian University (Save the Mothers) for their excellent guidance which sustained my interest up to the completion of this dissertation.

I extend special appreciation to Save The Mothers (STM) Director, Dr. Mushin Nsubuga and his team for the miraculous support he accorded to me that enabled me to defend and graduate. My deep-felt appreciation, goes to my dear husband Mr. Aloto Henry, loving children Osanga Happie, Maar Gracious and Ofumbi Ethan not forgetting my Pastors Bishop Lwandasa Samuel and Margret Nagayi Lwandasa who were always praying for me, my colleagues from Soroti district local government for their continued support and encouragement to see me complete this dissertation and special thanks to my brother Dr.Inangolet Francis Olaki for paying part of my tuition.

Finally, I am grateful to the disabled expectant women and the midwives of Soroti district especially those in charge, for helping me with the necessary information needed in the dissertation. May God bless you abundantly.

Table of Contents

Declaration 2
Supervisor's Approval 3
Dedication 3
Acknowledgement 5
List of figures 7
List of Tables 8
List of acronyms 9
Operation Definitions 11
Abstract 12
Chapter 1.0: Introduction 13

1.1Background 13
1.2. Problem statement 14
1.3. General Objective 15
1.4. Specific objectives 15
1.5. Research questions 15
1.6. Scope of study 16
1.6.1 Geographical scope 16
1.6.2 Time scope 16
1.6 .3 Content scope: 16
1.7. Justification 16
1.8. Theoretical model 17
CHAPTER 2: LITERATURE REVIEW 18

2.1 The concept of disability 18
Table 2: Showing statistics of disabilities in Soroti District. 19

2.2 Disability and pregnancy 19
2.3.0 Health facility infrastructure to accommodate disabled pregnant women... 20
2.3.1 Lack of sensitivity 22
2.3.2 Social support 23
2.3.3. Health care workers' attitudes 24
2. 4 The challenges faced by disabled expectant women when accessing health care services. 26
2.5 Challenges midwives experience as they handle pregnant women with disability. 27
2.5 .1 Knowledge on Health Facility readiness 29
2.5.2 The attitude of the Physically disabled women towards health workers. 30
2.6 Summary 30
CHAPTER 3: RESEARCH METHODS 32

3.1 Study design 32
3.2 Study Population 32
3.3 Sample size. 32
3.4 Sampling procedure 33
3.5 Sampling techniques 33
3.6 Methods of data collection method and Tools 33
3.6.1 Interviews 33
3.6.2 Observation method 34
3.7 Data collection instrument 34
3.7.1 Use of in-depth interview guide 34

3.7.2 Key informant interview guide 35
3.7.3 Observation check list 35
3.8 Data analysis 35
3.9 Data Management: 35
3.10 Ethical considerations 36
3.11 Challenges encountered 36
CHAPTER 4: FINDINGS 38

4.1 Introduction 38
4.2 Background Characteristics 38
4.2.1 Demographic characteristics of the respondents presented the profile of the respondents in general and the findings are presented in the tables. 39
4.3. Findings from the Study on the status of infrastructure and service delivery. 41
4.3.1 Status of the heath facilities infrastructure and provision of quality health care delivery services 41
4.3.2 The challenges that hinder women with disabilities from accessing quality delivery services 43
4.3.3 The challenges midwives experience in providing quality services to physically disabled expectant women 48
Chapter 5: Discussion of Findings 52

5.1. Discussions of findings 52
5.1.1. The health facility readiness in providing quality health care delivery services 52
5.1.2. The challenges faced by disabled expectant women in accessing the delivery services 52
5.1.3. To describe the experience of midwives in providing services to the disabled expectant women in the health facilities 54
Chapter 6: Conclusions and Recommendations 55

6.0. Conclusions 55
6.1. Recommendations 57
6.2. Limitations of the study 57
REFERENCES 59

APPENDIX I: Interview guide for midwives 63
Appendix 3: Health Facility Observation Checklist 66

List of figures

Figure 1: Challenges that hinder physically disabled expectant women from accessing quality delivery services.

List of Tables

Table 1: The common disabilities in Uganda

Table 2: Showing statistics of disabilities in Soroti District.

Table 3: demographic data of women with physical disabilities

Table 4: demographics data of the midwives

Table 5: Equipment devices/tools available in the health facilities
Table 6: Common disabilities among pregnant women.
Table 7: The challenges midwives meet when providing care to expectant disabled women in these health Units.

List of acronyms

AIDS	Acquired immune Deficiency Syndrome
DHT	District Health Trainers
HC	Health centre
HIV	Human Immune Virus
HSSIP	Health Sector Strategic and Investment Plan

HWAF	Health Workers Advocacy Forum
MOH	Ministry of Health
NGO	Non-Government Organization
PWD	Persons With Disability
SRH	Sexual and Reproductive Health
UN	United Nations
UNFPA	Uganda National Family Planning Association
USAID	United States Agency for International Development
WHO	World Health Organisation
NPHC	National Population and Housing Census

Operation Definitions

Accommodation refers to changing something to suit someone's wishes providing someone with something he needs. It typically involves making something fit.

Health facility is a place that provides health care and they include hospitals, clinics, outpatient care cent, and specialized care centre, such as birthing centre and psychiatric care centre, health centres III, IV and referrals.

Readiness is the availability of components required to provide services such as basic amenities, basic equipment, standard precautions, laboratory tests, and medicines and commodities. In summary, health facilities readiness is the capacity of the health facilities to deliver services to the people with disabilities.

Physically disabled Woman: This is a woman with a disability, especially a physical disability

Disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities and may be present from birth or occur during a person's lifetime is lack of ability to perform some function.

Abstract

Introduction:

The care for disabled people especially the disabled expectant mothers is a very big challenge in most health facilities in Uganda today. The readiness to accommodate the physically disabled people in most health care facilities especially in the public facilities has continued to pose a challenge for both the medical personnel and the caretakers of the disabled beneficiaries of these services. This study aims at assessing the health facilities' readiness to accommodate physically disabled expectant women in Soroti City.

Methods:

This was qualitative research with phenomenological study design and three methods for data collection were used.

(1). In-depth interviews involving 10 midwives from 10 health facilities within Soroti City.

(2). Feedback sessions from 60 physically disabled expectant mothers on the services acquired from the various health centres.

(3). Observations of both on-going activities within the health facilities where the physically disabled expectant mothers receive services from and review of the existing records and data collection books. All these techniques were used in the data collection process for both the primary and secondary data.

Results: The findings from 60 respondents and the 10 midwives as the sample from the total target population in the health facilities revealed greater insights into the readiness of these facilities to accommodate these physically disabled expectant women in Soroti City. More specifically, the research identified four main factors/challenges that influence the ability for the facilities to accommodate these physically disabled expectant women including: poor physical accessibility, language barrier, negative attitudes of health workers and long queues at the health facilities. The midwives also experience a lot challenges when providing care to physically disabled expectant women especially in the provision of ANC, Labour, Emergencies, Post-natal, and mobility within the facility. These challenges include: language barrier, poor attitude of the women, poor response to post antenatal services, shortage of assistance devices such as wheel chairs, crutches, and beds that do not support them in delivery.

Conclusion: The health facilities are ready to accommodate disable expectant women to a small/limited extent. The study therefore recommends that in order for physically disabled expectant women with disabilities to enjoy their rights, there is need for certain measures to be put in place which include: awareness on Sexual and Reproductive Health (SRH) and disability, improving physical access to medical facilities, staff development among medical personnel, and adapting materials to fit persons with disabilities.

Chapter 1.0: Introduction

1.1Background

In 1976, the World Health Organization drew a distinction between an impairment, a disability, and a handicap through the following definitions:(a) An impairment is any loss or abnormality of physically or anatomical structure or function; (b) A disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being; while (c) a handicap is a disadvantage for a given individual, resulting from impairment or a disability that prevents the fulfilment of a role that is considered normal (depending on age, sex and social and cultural factors for those individuals.

According to the United Nations standard Rules on the equalization of opportunities for Persons with disabilities. The term "Disability'' summarizes a great number of different function limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. It's important to note that such impairment, conditions or illness may be permanent or transitory in nature.

The 1975 United Nations Declaration on the Rights of Disabled Persons defined a disabled person as anyone unable to ensure by himself, wholly or partly, the necessities of a normal individual and or social life as a result of deficiency, either congenital or not, in his or her physical or mental capabilities. This definition stresses the inabilities of persons with disabilities and their dependence on assistance, since this was written. Attitudes towards disability have shifted for instance the term disabled person has been largely replaced in common use by persons with disabilities because the latter places emphasis on the person and not his or her disability.

Disabled persons are part of the communities we live in and according to (Eliphaz 1996), the disabled persons began to be recognised in 1987 with apparent unresolved challenges. The WHO/World Bank World Report on Disability 2023 estimates that 16% of the population of 1.3 billion people live with some form of disability worldwide. Persons with disabilities make up a significant part of the world's population– an estimated one in every six people, amounting to 208 million people (UN, Factsheet on persons with disabilities, 2007). Persons with disabilities make up 10% of the world's population overall and a disproportionate 20% of all persons living in poverty in developing countries are persons with disabilities (World Bank, 1999).

According to the population and housing census report (2014), overall, for the population aged 2 years and above the disability prevalence rate was 12.4% while the equivalent for 5 years and above was close to 14%. Sex differentials reveal that disability is higher among women compared to men. The disability prevalence rate was higher among those living in the rural areas compared to those in the urban areas. The population with disability in Soroti District stands at 39,482 based on the NPHC 2014.

Table 1: The common disabilities

Disability	Number of disabled persons
Hearing impairment (deaf)	9,441
Vision impairment (blind)	20,072
Mental illness	17,172
Physical impairment	13,413

Source: Uganda National Population and Housing Census 2014

Physical impairments include all persons who have impairments that affect gross movement or mobility for example, spinal bifida, cerebral palsy, spinal cord injury, amputation and orthopaedic impairment, muscular dystrophy and long-term conditions such as multiple sclerosis and arthritis which also affects fine hands and finger movements. Clients with disabilities may have physical, mental, sensory, learning disability or other impairments; but for the purpose of this study, the researcher will only look at the physically (handicapped) disabled with lower limbs and upper limbs disabilities and the back bone disability.

1.2. Problem statement

The Government of Uganda (GOU) has increased access to health services through various programmes and projects including investment in health infrastructure, medicines and other health supplies; and human resource development. Despite the investments, the desired universal health coverage is far from attainment as some sections of the population particularly persons with disabilities fail to have easy access to basic health care services. The UNCRPD (2007) guarantees PWDs the right to access the same range, quality and standard of free affordable healthcare and programs as provided to other persons. The Disability Act 2006 also entails PWDs rights that include equal access to services like health but still a gap exists which is due to the physical structure of the health facilities and attitude of the health service providers (Peters et al. 2008). In Uganda, as per the last

National Population and Housing Census, the overall population aged 2 years and above of persons with disability stood at a prevalence rate of 12.4 percent while the equivalent for 5 years and above was close to 14 percent. Soroti City alone had over 14.2 %, PWDs and 9.4% have limited/no accessibility to health care services (Moses et al.2014). In Soroti City midwives refer the physically disabled pregnant women to Soroti referral hospital for future management. This is because there are no theatre services and limited equipment to cater for the needs of women with disability in health centre 11 & IV in the City. In Soroti City health centres, there are indicators of unsatisfactory heath care services for pregnant women with physical disabilities evident in terms of non-functional equipment, fewer numbers of equipment in the facilities and fear by midwives to attend to pregnant women with physical disabilities. The physical disability level of Soroti City being higher than the national disability rate of 12.4% and showed that Soroti City was in need of interventions to address the disability gaps in all areas including health facility preparation to provide services to the physically disabled women given its prevalence of persons with disability. Upon this background that the researcher investigated Health Facility Readiness to aaccommodate pregnant women with physical disabilities in Soroti City.

1.3. General Objective

To assess health facilities readiness to accommodate the expectant women with physical disabilities in Soroti City.

1.4. Research questions

i). What infrastructure is available to accommodate pregnant women with the physical disabilities?

ii). What challenges do pregnant women with physical disabilities when accessing health care services?

iii). What are the midwives 'attitude while providing health services to pregnant women with physical disabilities?

1.5. Specific objectives

The study will address the following key objectives:

i) To assess the health facility infrastructure for health care available to accommodate physically disabled expectant women in Soroti City.

ii) To understand the challenges faced by physically disabled expectant women when accessing health care services.

iii) To explore the challenges midwives experience while providing services to physically disabled expectant women in Soroti City.

1.6. Scope of study

1.6.1 Geographical scope

The study was carried out in Soroti City; Eastern region of Uganda. Soroti City is an urban centre surrounded by Soroti District. Soroti City is located approximately 116 kilometres, by road, northwest of the city. According to NPH **Census** (2014) the Population of Soroti City is 49,452 of which 9.8% were PWD. The study was carried out in selected health units in the two divisions that make up Soroti City.

1.6.2 Time scope

The study utilized data for 5 years from 2017 – 2021. The period is preferred because this is when women with disabilities reported many challenges with health service delivery system in Soroti City.

1.6 .3 Content scope:

This study investigated health facilities readiness to accommodate the pregnant women with physical disabilities in Soroti City. The health facilities readiness was assessed through health facility infrastructure, the challenges faced by pregnant women and the challenges midwives experience while providing services to disabled expectant women in Soroti City.

1.7. Justification

In terms of theoretical significance, this study assessed the gap in the readiness of the health facilities to accommodate pregnant women with physical disabilities by describing the following issues: first, the study assessed the health facility infrastructure available to provide health care services to pregnant women with physical disabilities. Secondly, this

study sought to describe the challenges faced by disabled pregnant women with physical disabilities in accessing the services. From a practical perspective, the findings of this study would benefit the (DHT) District Health trainers and officers in charge of Health units/facilities as a basis for continuous assessment of the health units readiness to accommodate pregnant women with physical disabilities. Health facilities could learn from the research on how to come up with policy options to improve health facilities readiness to accommodate pregnant women with physical disabilities. The community shall also be helped to know the barriers that may prevent pregnant women with physical disabilities to access the maternity health services. The academicians interested in disability studies may learn from the research and expand upon their research. And lastly, since this research is in partial fulfilment of my MPH, it would lead to an award at the end of my research period.

1.8. Theoretical model

The study was guided by the Social Model of disability developed by Finkelstein (1993) and Hunt (1966). The social relational theory states that social exclusion of people with disability was an outcome 'of the materialist landscape of the industrial era' rendering them economically unviable. According to Solder (2009), the Social Model explained that disability arose from barriers within 'an oppressive and discriminating society' rather than impairment per se. The social model of disability saw disability as a socially-created problem and not at all an attribute of an individual. The social model, asserted that disability demands a political response, since the problem was created by an unaccommodating physical environment brought about by attitudes and other features of the social environment. The rationale for the social relational model of disability was better conformed to the morality of inclusion. This then shifted the onus of response away from the individual to society to dismantle barriers that construct disability.

The Social Model of Disability recognised that the built environment was a disabling instrument in itself, it was of great significance to build environment practice. The model was found relevant for this study because it was centred on disability and the environment which could render people with disability economically unproductive.

CHAPTER 2: LITERATURE REVIEW

2.1 The concept of disability

According to (Werner, 2010), disability is a long-lasting or permanent defect that in some way makes it difficult for a person to do certain things like a “normal” person. Disabilities may be mild, severe or moderate, mild disability is one in which the disability causes some inconvenience but the person can learn to do everything he/she needs to do alone with no help or with minimal help. Moderate disability is one in which the person needs to make adaptation to be independent in self-care and other activities for example white carne, wheel chair crutching while a severe disability is one in which the person will always need help and care. The World Health Organization (WHO, 2017)defines disability as ‘an umbrella term covering impairment, activity limitations and participation restrictions referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors). Disability is not just a health problem; it is a complex phenomenon reflecting the interaction between features of the person’s body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities required interventions to remove environmental and social barriers. It important to understand that People with disabilities have the same health needs as non-disabled people. They may also experience narrow margin of health, because of poverty and social exclusion and also due to vulnerable to secondary condition, such as pressure sores and urinary tract infections. It’s clearly evident that people with disabilities face barriers in accessing health and rehabilitation services they need in many settings.

Table 2: Showing statistics of disabilities in Soroti District.

Person with a disability	Number	Percentage
Persons aged 2 years and above with a disability	38,470	14.2
Persons 2 years and above with a seeing disability	19,454	7.2
Persons 2 years and above with a hearing disability	9,286	3.4
Persons 2 years and above with a walking disability	13,102	4.8
Persons 2 years and above with a remembering disability	16,816	6.2
Persons 2 years and above with multiple disabilities	11,195	30.2
Children 2-17 years with a disability	10,766	7.5
Youth 18-30 years with a disability	6,390	9.8
Older persons 60years and above with a disability	7,641	66.0

Source: NPHC 2014, Soroti District area profile

Basing on the data presented in the table above, disability in Soroti district as a whole is an issue that needs to be addressed.

2.2 Disability and pregnancy

In Uganda, 14.5% of persons with disability are women and those in reproductive age are more susceptible to poor pregnancy outcome due to their anatomical nature (**UDHS 2016**). Research has established that 82.3% of women with physical disability attended ANC during pregnancy, and of these, 80.8% delivered their babies at health facilities. Physical disabilities among women have created a gap in planning service in the country. Women with disabilities are growing in number and increasingly interested in becoming mothers and raising children. However, health care providers are often unfamiliar with the health care needs of this group of women and overlook the important issues that make the difference between positive and negative experiences of these women. However, Limited information about the potential interaction of their disabling conditions with pregnancy and childbirth exists to guide these women and their clinicians. According to MoFPED (2019) the medical

equipment that Government and development partners procure partly excludes the needs of persons living with disabilities. This therefore makes it clear that women with physical disabilities in Uganda $A = \pi r^2$ not receiving proper medical care though they have right to health.

2.3.0 Health facility infrastructure to accommodate disabled pregnant women.

Ganle (2016), explored the challenges women with disabilities encounter in accessing and using institutional maternal healthcare services in Ghana. Semi-structured in-depth interviews were used to gather data. Attride-Stirling's thematic network framework was used to analyze the data. Findings suggest that although women with disability do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled care, as well as gain access to unfriendly physical health infrastructure. Other related access challenges include: healthcare providers' insensitivity and lack of knowledge about the maternity care needs of women with disability, negative attitudes of service providers, the perception from able-bodied persons that women with disability should be asexual, and health information that lacks specificity in terms of addressing the special maternity care needs of women with disability.

Agarwal (2016) established that when infrastructure is inaccessible to any social group, that group is at risk of social exclusion, unable to participate in and contribute to society. He urges that Infrastructure is critical, as it is the means by which other services are accessed, including health and education. Urban environments without a universally accessible transport system will exclude people living with disabilities, marginalizing them and breaching their human rights.

The Orthopaedic Training Centres seems to be the only rehabilitation unit that responds to patients with physical rehabilitation throughout, Danso et al, (2011) urges that understandably, PWDs may seek care from the health facilities other than rehabilitation inpatients units, yet they $A = \pi r^2$ underrepresented in the health system. The units separate them completely from the entire other people and discriminate them from receiving medication together with other considered normal people.

Idanso*et al* (2017), assessed the accessibility of built infrastructure facilities for persons with disabilities Sofoline Interchange, and established that the facilities needed by the physically disabled pregnant women such as wheel chairs, adjustable beds, special designed toilets and have not been incorporated into the design of the Sofoline Interchange, making it unfriendly to the visually impaired.

According to Mensah *et al* (2008) reported that the barriers physically disabled women access to health care span from health financing as the funds are limited, structural and physical environment, he based his study in Ghana and discovered that the health facilities don't provide disability friendly services making it difficult for most clients especially wheel chair users to access hospital buildings as they lack the ramps and specialized lifts for them and more so they are not able to climb onto the medical examination beds to attain treatment and the health service providers have no ideas to help them out.

In Uganda despite the investments in the health sector, the desired universal health coverage is far from attainment as some sections of the population particularly persons with disabilities fail to have easy access to basic health care services. Article 25 of the UN Convention on the Rights of Persons with disabilities (CRPD) states that Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. It also states that Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive, including health-related rehabilitation. However, the infrastructure and medical equipment that Government and development partners procure partly exclude the needs of persons living with disabilities. (MOFPED 2019). **A**reas. These measures which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to interior of Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces. States parties shall also take appropriate measures to: Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public, ensure that entities that offer facilities and services which are open provided to the public take account all aspects of accessibility for persons with disability, provide training for stakeholders on accessibility issues facing persons with disability, Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms, Provide forms of live assistance and intermediaries,

including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public, Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information, Promote access for persons with disability to new information and communications technologies and systems including the internet and promote the design, development, production and distribution, access to information and communications technologies and systems at an early stage, so that these technologies and systems become accessible.

2.3.1 Lack of sensitivity

States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that gender sensitive including health related rehabilitation. In particular states Parties shall provide persons with disabilities with the same range, quality and standard of free affordable health care programmes as provided to other persons including in the area of sexual and reproductive health and population based public health programmes, provide those health services needed by persons with disabilities especially because of their disabilities including early identification and intervention as appropriate, services designed to minimize and prevent further disabilities, including among children and older persons, prohibit discrimination against persons with disabilities in the provisions of health insurance and life insurance where such insurance is permitted by National Law, which shall be provided in a fair and reasonable manner.

According to Uganda National health policy (2010), health sector strategies investment plan states that 'the government should ensure high quality health services which are available and accessible to all, including vulnerable & marginalise populations such as people with disabilities', but you find that the hospitals with elevators are often congested, and sometimes they do not work. Uneven access to buildings (hospitals, health centres) medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities and inaccessible parking areas create barriers to health care facilities, for example women with mobility difficulties are often unable to access breast and cervical screening because exanimation tables are height adjustable and mammography examination equipment only

accommodates women who are able to stand. It also requires that states parties not only promote the design development production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum costs.

2.3.2 Social support

Human resource is a key in service delivery especially in lower-level health facilities in communities and one of the indicators used for achieving of the same millennium Goals. The proportion of established posts filled by qualified health workers increased from 34% in 1999 to 53% in 2003 (MOH 2003) and 68% in 2004/2005; although the numbers of health workers had improved, it is still inadequate for delivery of facility readiness to accommodate the physically disabled pregnant women. According to the current staffing norms HC IIIs and IVs are provided with 2 and 4 midwives respectively, but these are inadequate, besides the fact that many positions are still not filled there is also inadequate distribution of personnel with over 80% doctors and 60% of midwives located in hospitals, hence least capacity to provide additional incentives to attract personnel. According to HWAF (2012) the human Resource for health situation in Uganda is still in a worrying state and significant gap since the available health work force cannot effectively deliver the national minimum health intervention package.

According to (AGHA 2012) Uganda through the Health Workers Advocacy Forum (HWAF) presented a statement to the Parliament social services committee demeaning urgent attention to the matter of the massive shortage of health workers particularly nurses and midwives in Uganda.
Malinga (2004) urges that Doctors and nurses posted at health unit should undergo facility-based care training. He further stressed that Training institutions for service providers need to be equipped with advanced/newer knowledge and skills of accommodating the expectant. However, the shortage of health workers suggest that the people of Uganda heavily rely on nurses, aid workers, and other sources of health-care to compensate for the inadequacy in the supply of doctors. It was reported that more than 16 percent of the physician workforce has migrated to high-income countries due to low compensation and poor working conditions. There is also a nursing shortage in Uganda, with a total of 16,000 nurses, or 0.61 per 100,000 people. Although, GOU (2015a) reports that nursing officers and nursing

assistants are in excess of the staffing norms at the district level. The number of clinical officers and enrolled nurses is also reported to be fairly adequate (94% and 85% respectively). The chapter notes that "staffing norms" in Uganda are not measured in proportion of the population and therefore do not conform to WHO standards. There is also ''internal migration'' or ''internal brain drain'' away from medical services to functions in the public health sector. In other words, many registered Ugandan physicians have shifted from medical services to positions with greater administrative or research duties in local and international organizations.

2.3.3. Health care workers' attitudes

Kpobi and Swartz (2019) conducted a study to compare attitudes among nurses, physiotherapy and occupational. The study revealed that nurses held the least positive attitude towards disability, while occupational therapy students showed the most positive attitudes. Other studies have also demonstrated personal attributes influencing attitudes towards disability; however, the findings reported $A = \pi r^2$ inconsistent. For instance, women held more positive attitudes than men in other studies (Akasreku, Habib & Ankomah, 2018). Additionally, other studies have report mixed findings on the correlation between age of health professionals and attitude towards people with disability.

In most developing countries around the world, people with disabilities may feel reluctant to access health services although they may have serious health problems that require health service intervention (Shaikh & Hatcher 2005:51). This is because of their experiences from previous attempts to access health services, particularly the attitudes and perceptions of health care providers. Therefore, patients' ability to accept and utilise services has a relationship with service providers' attitudes (d'Ambruoso, Abbey & Hussein 2005; Jones et al. 2008; Shaikh & Hatcher (2005). The attitudes towards people with disabilities have been identified as stigma, for example, stereotypes, wrong perceptions and the use of abusive and discriminatory words (Iezzoni 2011). This may limit them from accessing health care compared with the non-disabled population.

The stigma and use of abusive words are mostly experienced amongst women with disabilities and make them more vulnerable than their male counterparts (Aunos&

Feldman 2002). Women with disabilities are most likely to experience stigma relating to marital and reproductive life.

For instance, as a result of parenting difficulties, most service workers and families of people with disabilities, particularly with intellectual disabilities, strongly support sterilisation of females with disabilities despite the concerns over the years to ban involuntary sterilisation (Aunos& Feldman 2002.).

Devkota et al (2017) examined the healthcare provider's attitudes towards disability and explored the experience of women with disabilities in maternal healthcare service utilization during pregnancy and childbirth using the mixed method approach. An attitude survey was conducted among 396 healthcare providers currently working in public health facilities in Rupandehi district of Nepal. Mean ATDP score among healthcare providers (78.52; SD = 14.75), was low compared to the normative score of 100 or higher. Nurses/auxiliary nurse midwives obtained the highest mean score (85.59, SD = 13.45), followed by general clinical health workers (Mean score = 82.64, SD 15.10). The lowest score was obtained by Female Community Health Volunteers (FCHV) (Score = 73.75, SD = 13.40) ($P < 0.001$). Younger providers were more positive compared to older age groups ($P < 0.001$). Similarly, providers working in urban health facilities compared to those working in rural health facilities, and non-Dalit providers compared to Dalit providers reported more positive attitudes towards disability ($P < 0.05$). However, there were no significant differences in ATDP mean scores between those who had or had not previously provided services for women with disabilities. The mean score difference between those who received disability training and who did not was also found statistically insignificant ($P > 0.05$). This may reflect the small number of individuals, who have had training on disability thus far, or the nature or quality of the training currently available. Overall, provider's attitude towards disability was found to be negative with poor knowledge and skills about providing services. This may have adversely impact maternal healthcare service utilization by women with disabilities. More organized, effective training for healthcare providers is required through on-going mainstream efforts to develop favourable attitudes towards disability. Further research on this subject is also needed.

Hannah (2022) examined the attitude of healthcare providers towards pregnant women with disability. The study employed concurrent mixed analytical procedure where both quantitative and qualitative approaches were employed. The study used a sample size of

170 healthcare professionals was used for the data collection while 10 expectant mothers with disabilities were used for the interview. 149 questionnaires were received and coded representing 86.47% response rate. The non-numerical data were analysed using content and thematic analysis. Analysis of variance (ANOVA) statistics was used to compare mean attitude scale score and interaction of background, exposure variables and professional status. Mean comparison and statistically significant was assessed using ANOVA statistics to understand the association between variables. It was found that although the healthcare professionals have often been dealing with expectant mothers with disabilities, they have very little training and the positive attitudinal value for women with disabilities is weak. Majority of the expectant mothers with disabilities had bad experiences with healthcare professionals.

Dassah et al (2019) investigated the attitude towards people with disability of nursing and physiotherapy students at the University of Cadiz. Methods: This was a descriptive, correlational, transversal and synchronous study. A total of 200 students participated in the study (91 from the bachelor's degree in nursing and 109 from the bachelor's degree in physiotherapy). The 'Attitudes towards people with disability scale' was used. The Results revealed that Attitudes towards disability of nursing and physiotherapy students at the University of Cadiz were positive.

2.4 The challenges faced by disabled expectant women when accessing health care services.

A study by Ganle et al (2016) explored the challenges women with disabilities encounter in accessing and using institutional maternal healthcare services in Ghana using qualitative research design. The study was conducted in 27 rural and urban communities in the Bosomtwe and central Gonja districts of Ghana with a total of 72 purposively sampled women with different physical, visual, and hearing impairments who were either lactating or pregnant at the time of this research. The findings suggested that although women with disability do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled care, as well as gain access to unfriendly physical health infrastructure.

. Doreen et al (2023) explore the experiences of women with disabilities in the province of KwaZulu-Natal in South Africa in accessing public maternal healthcare services. The objectives of the study were to describe the experiences of women with disabilities in accessing maternal healthcare services during pregnancy, childbirth and post-partum care; explore the inhibitors of access to maternal healthcare services for women with disabilities; and explore the facilitators of access to maternal healthcare services for women with disabilities. The study established that narrow passages and information in inaccessible formats were a challenge for women with visual impairments. Women with hearing impairments faced communication difficulties due to the lack of sign language interpreters in most facilities. Moreover, healthcare professionals displayed unfavorable attitudes toward women with hearing impairments, and these women were often overlooked when seeking help.

2.5 Challenges midwives experience as they handle pregnant women with disability.

According to Biair (2022), the midwives need to have disability awareness and positive attitude on expectant women with physical disabilities in the health facilities. He also noted that understanding on the experiences of women with physical disability who are expectant is of great value to the midwives.

Mitra, Long-Bellil, et al. (2015) identified the need for information among women with physical disability as a critical component of the perinatal health framework for women with physical disability and one that affects their experiences throughout their perinatal experience. Their findings support the view of others that little has changed for pregnant women with physical disability in the last 20 years despite increased attention to the lack of appropriate care and information for them and the number of women with physical disability pursuing motherhood (Heideveld-Gerritsen et al., 2021; Tarasoff, and Tarasoff et al., 2020).

According to Shrestha et al (2022), the pregnant women with physical disabilities had difficulty lacked knowledge regarding contraception use and sexual health resulting in violations of their reproductive rights. Sexually transmitted diseases and cervical cancer are

common among IDW due to their vulnerability to sexual abuse. Null parity in IDW increases their susceptibility to even breast cancer. its therefore important for Reproductive and sexual health education including contraception use could be provided by using evidence-based strategies involving use of pictures, animations and models by adequately trained healthcare providers including midwives.

Nguyen et al (2019) examined the existing literature on the experiences and challenges facing Women with Physical Disabilities (WWPD) in accessing and utilization of these services during pregnancy, childbirth and the post-natal period. Fifteen studies that met inclusion criteria were identified. Findings from the review highlight that pregnancy and motherhood are meaningful for WWPD in both individual and socio-cultural ways. Multiple challenges facing WWPD were identified, including low self-esteem and confidence, negative responses and lack of family support, problematic experiences of transport, health and other social systems for maternal healthcare of WWPD, and social unacceptance and discrimination from the community.

Matin et al. (2021) conducted a systematic review of relevant qualitative articles in PubMed, Web of Science and Scopus databases from January 2009 to December 2017. The search strategy was based on two main topics: (1) access to healthcare; and (2) disability. In this review, women (older than 18) with different kinds of disabilities (physical, sensory and intellectual disabilities) were included. the Findings revealed that WWD faced different sociocultural (erroneous assumptions, negative attitudes, being ignored, being judged, violence, abuse, insult, impoliteness, and low health literacy), financial (poverty, unemployment, high transportation costs) and structural (lack of insurance coverage, inaccessible equipment and transportation facilities, lack of knowledge, lack of information, lack of transparency, and communicative problems) factors which impacted their access healthcare.

2.5 .1 Knowledge on Health Facility readiness

Some information on the health facilities readiness is necessary for the health system to accommodate and give services to their communities. According to the World Health Organization (WHO, World report on Disability, 2017) guidelines, facilities readiness is measured by resources, health worker knowledge and attitude and planned documents. Facilities readiness refers to the ability of health facilities to offer specific service and the capacity to provide that service measured through selected tracer items that include trained staff, guidelines, equipment, diagnostic capacity, and medicines and commodities.

A study by Mitra, M. et al. (2016), on Pregnancy among women with physical disabilities revealed that Many women reported that their clinicians were less knowledgeable about their specific disability than they would have preferred, some offered inaccurate information, and some expressed negative stereotypes about people with disabilities. One obstetrician warned a woman who used a wheelchair that she would “automatically deliver at 26 weeks,” and if her child were to survive the pregnancy, it “would be mentally and physically disabled.” The women perceived these statements to be solely based on the fact that she uses a wheelchair. the scholars also revealed that some Participants often encountered inaccessible medical offices and equipment, including exam tables, weight scales, bathrooms, and hospital beds. Several women reported not ever being weighed throughout their pregnancy. Some clinicians tried to guess their weight by looking at them, while several were weighed while their partner held them.

Mariëlle (2021) conducted systematic review is to identify maternity care experiences of women with physical disabilities, including sensory disabilities. The search strategy focused on qualitative studies in the databases PubMed, Embase and CINAHL. The results indicated that women experience barriers related to accessibility of facilities, adapted equipment, lack of knowledge, and healthcare providers' dismissals of their concerns and unwillingness to assist. Therefore, its evidence that women with physical disabilities continue to encounter barriers in accessing maternity care related to inaccessible care settings, lack of knowledge and the attitude of healthcare providers.

2.5.2 The attitude of the Physically disabled women towards health workers.

A study by Florence et al (2014) assessed, physically disabled pregnant women's perceptions of the attitudes and practice of midwives during labour in a mission teaching hospital and a state hospital in Ogbomoso, Southwest Nigeria, and determined whether or not a relationship exists between patients' perceptions of midwives practice during delivery and the occurrence of neonatal deaths. Methods: The survey was conducted by administering the questionnaire adapted from Caring Behaviour Inventory (CBI) to a random sample of five hundred and seventy-nine respondent mothers who gave birth in either a Mission teaching hospital or a state hospital in Ogbomoso, Southwest Nigeria. the study revealed that there was a positive response on the attitude and practise of midwives during delivery by the respondents. Secondly, there was a positive impression on the influence of the attitude and practice of midwives during delivery by the respondents.
Bwalya, et al. (2015) explored the perceptions, beliefs and attitudes of expectant women towards male midwives conducting deliveries in health institutions of Chikankata, Kabwe, Mansa and petauke districts. A descriptive cross-sectional study was conducted over 200 pregnant women attending antenatal Clinics selected using simple random sampling method. The findings revealed that many pregnant women wouldn't accept to be delivered by a younger male. Many agreed that male midwives were skilled professionals, trusted female midwives, were fine with female midwifes, wouldn't want to share obstetric information with a male midwife caring for them. There is a need to intensify health education to encourage pregnant women to utilize birth skilled attendants regardless of gender in order to reduce maternal mortality.

2.6 Summary

The infrastructure and facilities available in most health facilities do not favor pregnant women with physical disabilities. Furthermore, scholars like Agarwal (2016) and Idanso*et al* (2017), urge that Infrastructure is critical, as it is the means by which other services are accessed, including health and education. Therefore, most of the barriers physically disabled women encounter in accessing healthcare span from health financing as the funds

are limited, structural and physical environment become unfavourable for women with disabilities.

Although women with disability do want to receive institutional maternal healthcare, their disability often make it difficult for such women to travel to access skilled care, as well as gain access to unfriendly physical health infrastructure. Scholars Doreen et al (2023) and Ganle (2016) have revealed that the challenges faced by disabled expectant women when accessing health care services include: narrow passages, information-inaccessibility formats were a challenge for women with visual impairments. Women with hearing impairments faced communication difficulties due to the lack of sign language interpreters in most cases.

In regard to the challenges midwives experience while providing services to disabled expectant women scholars such as Biair (2022), Mitra, Long-Bellini, et al. (2015) and Shrestha et al (2022) reported

that the pregnant women with physical disabilities lacked knowledge regarding contraception use and sexual health resulting in violations of their reproductive rights. Sexually transmitted diseases and cervical cancer are common among IDW due to their vulnerability to sexual abuse. Null parity in IDW increased their susceptibility to even breast cancer. Its therefore important that Reproductive and sexual health education including contraception use be provided by using evidence-based strategies involving use of pictures, animations and models by adequately trained healthcare providers including midwives.

CHAPTER 3: RESEARCH METHODS

This chapter presents the various methods and procedures the researcher adopted in conducting the study. The chapter highlights the research design indicating the defined design, population and sample, data collection methods, sampling design and sample size, research procedures and data analysis plus ethical considerations and challenges encountered during the study.

3.1 Study design

The study employed a phenomenological study design, which lays emphasis on description and understanding of human conscious experience as it's lived in the world (smith et al 2009). The design was adopted for the study because it examines human experiences through the descriptions provided by the individuals involved. The mixed methods approach involving both quantitative and qualitative approaches was also used.

3.2 Study Population

The primary study population were 15 women with physical disabilities who had ever given birth and who were pregnant and 10 midwives providing delivery services to women with physical disabilities in the 27 health facilities in Soroti City. The study population was 25 respondents, comprising of 15 pregnant women with physical disabilities attending antenatal clinic and 10 midwives providing delivery services to women with physical disabilities.

3.3 Sample size.

The data collection method of in-depth interviews, key-informants and observation guided the research choice of the sample size was used.
The sample size of 25 respondents were purposively selected from the 22 health facilities in Soroti City. The health facilities included one referral hospital, 3 health centre IV and 18 HC III.

The sample size was theoretical saturation. It was aimed to collect data until no new themes or insights emerged

3.4 Sampling procedure

The research used purposive sampling statement to select participants who provided rich and detailed information about the phenomenon being studied
The study being qualitative and given that the study intended to involve participants who are not easily accessible in the various points in the community. The midwives on duty helped to call out the disabled present at the health facility. Each woman called was briefed about the study before engaging in an in-depth interview. For purposes of ensuring privacy, convenient places of the interviews were selected with the guidance of the midwives.

3.5 Sampling techniques

The sampling frame consisted of pregnant women with physical disabilities obtaining health care from health facilities in Soroti City from Monday to Friday as well the midwives on duty providing health care services to pregnant women with physical disabilities.
Purposive sampling technique was applied to both the pregnant woman with physical disability in the line awaiting services and midwives on duty attending to the women with physical disabilities. This technique was used because it helped the researcher to select only those respondents with ample technical knowledge of the subject so as to access technically required information. Therefore, in each health facility, a total of 2 midwives were selected. This sampling technique was also applied to referral hospital in the Municipality, the three HC IV in the municipality and the Six HC III because they provided delivery services to women.

3.6 Methods of data collection method and Tools

Methods of data collection included observation and interviews. They were used because they ensure high quality data.

3.6.1 Interviews

According to Mugenda and Mugenda (2003) an interview guide makes it possible to get the required data to meet the study objectives, in that it provides in-depth data that is not possible to get using questionnaires. Interviews were used for data collection because they are flexible and can be used to obtain well explained information from many people. The researcher generated information by conducting key informant interviews based on unstructured open –ended questions. The researcher utilized qualitative interviewing

methods as a primary strategy for data collection because they allow for individual variations and gives the researcher opportunity to respond in order to uncover how people think and feel about the circumstances in which they find themselves (Thome ,2000).

3.6.2 Observation method

The researcher used observation checklist in the health facilities as they are structured tools used to systematically record and evaluate patients care clinical procedures other medical related activities, hence consistence and evidence based.
Enhances reliability of care and improves patients' outcomes and reduces errors

This helped the researcher collect data on health facilities readiness to accommodate pregnant women with physical disabilities in its current form without requiring active cooperation of the respondents (Kothari, 2004). Through the observation method, the researcher was in position to obtain additional, unexpected but useful information which helped us formulate our own version of what is occurring in health facilities infrastructure and pregnant women with physical disabilities in Soroti City.

3.7 Data collection instrument

These included the specific instruments the researcher used to collect data.

3.7.1 Use of in-depth interview guide

The In-depth Interviews is a qualitative data collection method they offer the opportunity to capture rich, descriptive data about how people think and behave, and unfolding complex processes. They can be used as a standalone research method or as part of a multi method design, depending on the needs of the research
The researcher used a recorder to help on accurate capture of conversation. Voice records allow verbatim transcription of interviews ensuring details are not missed. The choice of the recorder was also because it can analyse tone, pace and language use providing additional insights into the data. The social scientist gathered rich detailed data, that provided valuable insights into the human behaviour, attitude and experiences of physical disabled expectant women in health facilities in soroti city. This was applied to pregnant women with physical disabilities. They contained both open and close ended questions. The close ended

questions were based on the 3 Scale format of:1=Available and functional, 2= Available and not functional, 3=Not available.

3.7.2 Key informant interview guide

Key informant interviews are qualitative in-depth interviews with people who know what is going on in the community. The purpose of key informant interviews is to collect information from a wide range of people including community leaders, professionals, or residents who have first-hand knowledge about the community. In this case the key informants' interviews were held with midwives providing health services to pregnant women with physical disabilities.

3.7.3 Observation check list

Observation checklist was used to collect data on the available infrastructure and equipment in the health facilities. The researcher physically assessed the equipment and infrastructure in each heath unit and recorded the statistics and status of the equipment.

3.8 Data analysis

Qualitative data was analysed thematically basing on the themes identified in the research objectives.

Content analysis was also used to infer meanings that arose as the researcher read the testimonies and submissions from the respondents. As we read the descriptions of the respondents, we made margin notes on the inferred meaning and underlying connotations in the subtext. These meanings formed the interpretations of the data and were much relied on to complete the discussion section. This technique was also used to make the presentation of results systematic, simplistic and organized.

The quantitative data was analysed manually using content analysis and it was presented descriptively following identified themes and also guided by the objectives.

3.9 Data Management:

The data was collected through the use of in-depth interviews for both women with disabilities and key informants where responses were recorded on paper. Interviews were undertaken in pairs i.e., researcher and respondent pairs to enable detailed note taking.

3.10 Ethical considerations

Consent considerations for interviews were obtained from the officer in charge of the unit, strict confidentiality was observed during data collection, storage, entry analysis and presentation of the result. It included the following:

Getting ethical clearance

This was got from UCU by submitting the proposal writing report to post graduate office for approval, from the DHO by submitting a request letter and permission from the in charges by showing them an approval letter from the DHO.

Participants' informed consent

This was got by explaining to the participants what the study was about which was to assessment of the health facilities readiness to accommodate women physically disabled in Soroti City in Soroti district. The participants shared what they knew about the study.

Confidentiality in data collection and report writing

The data was collected during working hours at the health facilities. Also, no personal name, facility or registration number was used in the course of data collection and the entire process of research work.

3.11 Challenges encountered

The major challenge that the researcher encountered was hesitation by respondents during data collection to release information. Some respondents were unwilling to fill in the questionnaire because they had other work to be done at the same time.

Some of the respondents misunderstood the questionnaire. Questionnaire were explained and interpreted where applicable. Some respondents found the questionnaire hard to understand so the researcher took more time to explain to them. Some respondents felt that the information required was sensitive and can affect their working environment if revealed. However, the researcher made an effort to convince respondents that the information exchanged was very confidential. Delays in filling of questionnaires were yet another problem that was faced due to the busy schedules by the respondents thus, the researcher had to re-visit.

Another major challenge were the resources including both time and money to carry out the research as movements from one health facility to another were very costly and key informants had busy Works.

CHAPTER 4: FINDINGS

4.1 Introduction

The general objective of this study was to assess health facilities readiness to accommodate the expectant women with physical disabilities and to understand challenges faced by physically disabled expectant women and to explore the attitudes of midwives while providing health care services to the physically disabled expectant women in Soroti City.

This chapter presents the findings of the study and is in four key sections:
The first section is the descriptive analysis of the background characteristics of the respondents. The second section represents status of the health facilities infrastructure. The third section analyses the changes faced by pregnant women with physical disabilities in accessing health services. The last section analyses the attitudes of midwives while providing services to pregnant women with physical disabilities.

4.2 Background Characteristics

The respondents sought included their gender, age and marital status, length of time one has served in the health facility (experience), occupation and level of education.

4.2.1 Demographic characteristics of the respondents presented the profile of the respondents in general and the findings are presented in the tables.

a). Demographic characteristics of women with physical disabilities

Table3: Demographic characteristics of physically disabled expectant women

:Age category	Frequency	Percentage
20-25 years	2	13.3 %
26- 30 years	5	33.3 %
31- 40 years	8	53.3 %
41 years and above	0	0%
Total	**15**	**100**
Marital status		
Married	5	**33.3**
Single	6	40%
Widowed	1	6.60%
Cohabiting	2	13.30 %
Divorced	1	6.60 %
Total	**15**	**100**
Level of education		
Primary	5	33.3%
Secondary	5	33.3%
Certificate	5	33.3%
Others	0	0.0%
Total	**15**	**100**
Occupation		
Teachers	2	13.3
Cleaners	1	6.6
Peasants	5	33.3
Business	1	6.6
Market vendors	1	6.6
Tailors	1	6.6
Hair dressers	1	6.6
Tailors	1	6.6
Craft makers	1	6.6
Bar attendants	1	6.6
Total	**15**	**100**

The finding in table 3 above reveals that of the total respondents, 13(86.6%) pregnant women with physical disabilities who took part in this study were aged 26- 40 years.

On marital status of women with physical disabilities6(40%) and 5(33.3%) of the pregnant women with physical disabilities were single and married respectively.

In regard to Education level of women with physical disabilities 5, (33.3%) at each level of the respondents had obtained a certificate.

The findings on the occupation of women with disabilities revealed that 5(33.3%) and 2(13.3%) of the pregnant women with physical disability were peasants and teachers respectively. The rest were 6.6% each.

b) Demographic characteristics of mid wives

The researcher took midwives as key informants during the study particularly those focused on maternal and child health, reproductive health and health care services. Midwives provide rich insight into areas of experts hence sharing their experiences and knowledge on primatal, delivery and post-natal care

Table 4: Demographic characteristics of midwives

Demographic factor	**Frequency**	**Percentage**
Age		
22-26 years	4	40
27 -31 years	2	20
32 -36 years	1	10
37-40 years	0	0
41- 45 years	1	10
Above 46 years	2	20
Total	**10**	**100**
Marital status of midwives		
Married	3	30
Single	3	30
Widowed	3	30
Cohabiting	1	10
Divorced	0	0
Total	**10**	**100**
Education level of midwives		
Diploma	3	30
Certificate	7	70
Total	10	100
Experience of midwives		
1-5 years	3	30
6- 10 years	4	40
11-15 years	1	10
Above 16 years	2	20
Total	10	100

The demographic characteristics of the mid wives were presented in table 4 above. In regard to the ages of the midwives interviewed a majority, 6 (60%) were aged 22-31 years and only 20% were aged above 46 years. This implies that the midwives were mature enough to provide information on the topic under investigation. The findings on marital status of midwives revealed that 30% of the midwives were married, 30% were single and another 30% were widowed. However, 10% were still cohabiting.

The findings in table 4 above revealed that 7 (70%) of the midwives who participated in the study had certificates while 30% were diploma holders. It was noted that none of the midwives had bachelor's degree

It was further established that 4 (40%) of the midwives had experience of 6- 10 years, 3(30%) had worked for 1-5 years and 20% had worked for more than 16 years. this revealed that most of the midwives were experienced enough in providing health care services to women with physical disabilities.

4.3. Findings from the Study on the status of infrastructure and service delivery

Introduction

The findings from the study were presented in line with the research objectives. This study was guided by three research objectives which helped to guide the findings using interview guide for women with disabilities, interviews with key informants and a check list for health facilities.

4.3.1 Status of the heath facilities infrastructure and provision of quality health care delivery services

to disabled expectant women.

Under this objective, the research aimed at finding out whether health facilities were ready to provide health care delivery services to disabled expectant women and this was to be proved by availability of assistive devices at the health facility, transportation assistance around the health facility using wheel chairs, stretchers, proper lighting of the health facilities for good visibility, presence of laundry, bathroom and toilet facilities, presence of

ramps to ease mobility around the health facility as well as presence of sign language and deaf-blind interpreters. The findings by the researcher are indicated in

Table 6 below. Therefore, assistive devices and services are available in a few health facilities and lacking in most of them. This shows that most health facilities are not well equipped to provide health care to disabled expectant women. To assess the facility readiness, the researcher interviewed and interacted with the midwives, health facility in-charges and they pointed out that to small extent the health facilities were ready to receive and treat expectant women with disabilities.

Table 5: Equipment devices/tools available in the health facilities

Status of Equipment /devices and tools available			
Devices/services	**Functional**	**Non functional**	**Total**
Wheel chairs	6	2	8
Crutches	-	-	0
Labour room (climbing blocks, hand support)	6	-	6
Hand railing	2	-	2
Proper lighting	6	-	6
Laundry (washing taps, washing bay)	2	-	2
Kitchen (water, stoves)	4	-	4
Transport (ambulance, Wheel chairs, motorcycle, stretchers)	3	1	4
Bathrooms (showers, taps)	7	-	7
Large doors	7	-	7
Ramps	7	1	8

Source: field research 2017

Table 5, above shows that most health facilities had some functional assistive devices such as wheel chairs, labour rooms with climbing blocks and hand support, proper lighting, bathrooms with taps, large doors and ramps. The status of the equipment and their availability therefore revealed that most of the health centres in Soroti City were under equipped with infrastructure for providing health care to pregnant women with physical disabilities. It has therefore been noted that due to stuffiest infrastructure in health centres the pregnant disabled women are not receiving satisfactory health care though they have a right to health.

4.3.2 The challenges that hinder women with disabilities from accessing quality delivery services

Under this objective, the researcher aimed at finding out the challenges faced by women with disabilities in accessing quality delivery services through interviewing various beneficiaries and service providers.

Types of disability

From the results of the study, it was noted that all the respondents acknowledged that there were different types of disabilities. The finding of the study indicated that most of the pregnant women with disabilities got their disability through accidents while others at birth or at a tender age. As indicated in Table 6.

Table 6: Common disabilities among pregnant women.

Type of disability	Frequency	Percentage
Limb deformities	8	53.3
Hearing impairment (deaf)	3	20
Visual impairment (blind)	4	26.7
Total	**15**	**100**

Source: field data (2017).

Of the 15 respondents with different types of disabilities,8 (53.3%) reported having limb deformities, 4(26.7%) had visual impairment and 20% had hearing impairment.

These were supported qualitatively by a number of expectant disabled women in in-depth interviews who pointed out that:

"The health workers received me like all the other women but I was given special attention more than other women to avoid standing in the lines for a long time. The nurses from hospital received me well and encouraged me to deliver from the health centre to avoid

complication since disabilities do not end on top. However, in the main hospital some of the midwives and nurses were rude to me". (Woman with a disability 1)

'If I go to the hospital now, how to get inside will be a problem. The entrance has a steep staircase that I can't climb with my wheelchair. Some of the offices too I can't enter with my wheelchair. It usually takes longer before the nurses help you enter. The last time I went to check my pregnancy I waited for almost 30 minutes'. (Woman with a disability2)

One visually impaired woman also reported:

"As I can't see it is always difficult to find my way around, especially if my husband is not around to help me. The health people too, they won't help you…the last time I went I almost tripped off the stairs. So, these are some of the problems I face." (Woman with a disability3)

The observation results indicated that most health facilities lack ramps; personnel to assist them such as helping them climb stairs; interpreters, proper lighting, crouches, wheel chairs and disability friendly beds in case of delivery or admission and separate toilets for them in health units.

This was supported by qualitative data were respondents pointed out that;

"Almost all the health facilities in our midst have steps and some have ramps with very poor cement mixture which the rains have kept making holes, hence difficulties in rolling wheel chairs. Therefore, moving upwards to other levels is very hard for us.'' (Woman with disability4)

The lack of appropriate and friendly facilities for physically disabled expectant women is a clear manifestation of the marginalization of physically disabled expectant women health needs. Furthermore, marginalization and vulnerability of physically disabled expectant women is illustrated in the reported attitudes of health workers, which were noted to be negative characterized by abusive language used when attending to mothers who come for antenatal care (ANC) and delivery at the health facilities. One of the female respondents noted:

"For me when I went for ANC when I was pregnant, health workers said, "even you in your status you sleep with men and more so you accept to conceive? Men do not forgive; imagine they also sleep with this disabled woman". (Woman with a disability5)

The statistics in Figure 1indicate that 30 (17%) disabled expectant women mentioned that the attitude of health workers was a challenge affecting their access to delivery services. This was supported by women interviewed that:

(They pointed out that," You know it is like women with physical disabilities should not conceive at all. When I go for pregnancy check-up the way midwives look at me, is like I have done something wrong! At times they are too rude to me but I have learnt to ignore them and just aim at getting someone to check the condition of my baby. We do not like the way society and health care providers treat us"

(Woman with a disability6)

Key informant interviews with midwives yielded the same sentiments, suggesting that negative health workers' attitudes are a major barrier to physically disabled expectant women s' access to services:

"I know when physically disabled women get pregnant, they are despised, not expected to conceive due to the assumption that they already have enough problems to deal with. This happens mostly with health care providers" (Key informant1)

The physically disabled expectant women were concerned about constant abuses related to their appearance which they noted to cause stigma and de-motivation from using health facilities. The above voices illustrate that physically disabled expectant women are expected by society to be concerned more about their disability.

Both physically disabled expectant women and key informants indicated that health facilities to small extent are ill-prepared to address the SRH (sexually Reproductive Health) needs of physically disabled expectant women. Most respondents mentioned that health care providers were not trained to handle physically disabled expectant women, and that some health care providers' subject females with physical disabilities to deliver by caesarean section, thereby minimizing their ability to deliver normally. This is particularly due to lack of skills to handle pregnant females with disabilities, as the following quotes illustrate:

"Service providers are not trained in special needs skills to handle physically disabled expectant women. Some health care providers get shocked when they receive pregnant physically disabled expectant women at health facilities. This should not be the case…" (Key informant2)

The statistics from Figure 1 indicate that 9(5%) mentioned that communication/language barrier was a challenge affecting their access to delivery services. This was supported by women interviewed that:

“Last time I went to the clinic to complain to the midwife about some pains I felt around my waist. But the midwife couldn’t understand what I was talking about…she just gave me paracetamol and asked me to go home.” (Woman with a disability 7)

Another said:

“It is frustrating to go to the clinic…nobody seems to understand me. When I go with my husband it is better because he understands me, and he then tells the nurses what I’m saying. But if I go alone, they don’t understand me.” (Woman with a disability8)

This implies that most of the account’s women gave suggested that many maternal healthcare providers mostly midwives at health facilities could neither understand nor appropriately communicate in sign language. This calls for either training of midwives on special needs programmes or employment of interpreters.

Furthermore, the statistics in Figure 1 indicate that 25 (14%) mentioned that long queues were a challenge affecting their access to delivery services. Long queues in the health facilities pose particular vulnerability to physically disabled expectant women, whose condition as opposed to the able-bodied clients may not stand the waiting time as these female respondents noted. The lack of positive discrimination by the health workers where physically disabled expectant are left to line-up with those who do not have disabilities is not good and should be put into consideration. This was supported by women interviewed that;

“If it was not lining up in health centre, I believe more women with physical disabilities would be going there for services. At times when I would go for ANC services, I would line up for a long time and sometimes I would get so tired and give up. Our hip bones are not strong enough to stand for a long time and when we are pregnant, we tend to feel weak and tired most of the time” (woman with a disability 9)

The statistics in Figure 1 indicate that 9 (5%) cited that Health workers are not experienced to handle/fear PWPDs as one of the challenges affecting their access to delivery services. Most of the health facilities use health assistants and nursing aids who are insensitive or lack knowledge of their care needs. This was supported by women interviewed that;

‘One time when I was pregnant, I went to see the midwife. As soon as I got to the health centre one of the nurses shouted to her colleagues ‘come and see a pregnant cripple’. I felt

really embarrassed. Since that day I have not been to the health centre'. (Woman with a disability10)

One woman with physical impairment said:

"I think most of the nurses just don't understand that as a disabled person, we have special needs. The other day I went to see the midwife. She just asked me to lie on the table…but the table was high. When I asked one of the nurses to help me, she just started shouting at me…she said why couldn't I climb and lie down myself. She didn't seem to understand that I couldn't stand on my own. She even said if I knew I couldn't climb the table then I shouldn't have been pregnant. She also said it wasn't her job to be helping cripples lie down on tables. I really felt bad." (Woman with a disability11)

Some participants also reported that information and advice from healthcare providers were sometimes irrelevant or not applicable to disabled women.

"Sometimes the nurses don't really think about my situation. When I was pregnant and went for check-up, the nurse said I should do exercise by walking every day. But look at me, I can't stand and walk. I can only move about in this wheelchair. So how do I benefit from this advice?" (Woman with a disability 12)

Several of the accounts here indicated that some healthcare providers were not only rude and insensitive but also, they appeared ill-prepared to address the maternity needs of women with disability. Accordingly, most caregivers were not trained to understand disability and to provide care to pregnant women with disability. Indeed, some participants reported that some caregivers were even nervous or uncomfortable examining them.

"At times you can tell that the nurses don't want to help you…sometimes too they are just afraid of you like you're a lion waiting to eat them up. But it's not like that. I'm a human being with feelings and so when I go to see the nurse and they treat me like an animal, I won't go again." (Woman with disability13)

The statistics in Figure 1indicate that 45 (25%) mentioned that long distance to health facility as one of the challenges affecting their access to delivery services. Interviews with the women suggested that mobility from their homes to health facilities to receive care was a major challenge. Most of the women with visual impairment and physical disability as well as those in rural areas particularly reported this challenge, perhaps, because access to maternal healthcare often involves travelling relatively longer distances.

'When I was pregnant, I wanted to go to the hospital to see the midwife but because of my condition I couldn't go.' (Woman with a disability 14)

Mobility problems were often compounded by resource constraints and a public transport system that is not disability-friendly.

'I really want to go and check my pregnancy. My problem is how to move from here to the health centre. I can't paddle my wheelchair to the health centre because it is far. If I had enough money, I will just hire a taxi to take me there…I can't also use the public bus because I can't get into the bus and even if I get somebody to help me into the bus where to put my wheelchair is a problem.' (Woman with a disability 15)

Although several women reported that cost of maternal healthcare was not a serious deterrence because of the free maternal healthcare policy, difficulties with mobility and the prohibitive cost involved in arranging appropriate transportation often prevented many women with disability from accessing skilled care.

4.3.3 The challenges midwives experience in providing quality services to physically disabled expectant women

Under this objective, the researcher aimed at finding out the challenges midwives experience when providing care to physically disabled expectant women. (Probe: ANC, Labour, Emergencies, Post-natal, Transport)

Table 7: **The challenges midwives meet when providing care to expectant disabled women in this health Unit**

Challenge	Frequency	Percentage
Language barrier leading to poor communication especially when dealing with the deaf and dumb	10	100
Poor hygiene of some disabled expectant women	3	30
Inadequate maternal services such as mama kits and lack of assistive devices and infrastructure for disabled expectant women	1	10
Lack of cooperation during labour	3	30
Fear of referrals	4	40
Failure to turn up for PNC	5	50
Lack of attendants to assist in health facilities	5	50
Aggressive and rude disabled expectant women	2	20

Table 7 above shows that 100% midwives were challenged by poor communication as a result of language barrier especially when dealing with the deaf and dumb. Half (50%) of the

midwives reported challenges where some disabled expectant women are aggressive and others failed to turn up for their post-natal care reviews. 4(40%) of the midwives reported that disabled women did not accept referrals to other health facilities with specialised care due to fear and transportation difficulties. 3(30%) of the midwives claim poor hygiene, inadequate maternal services and lack of cooperation from the disabled women as the major challenges and 2(20%) of the midwives say that they are challenged when the expectant disabled women did not have attendants to assist them at the health facility.

From the findings of the study, the midwives acknowledged that they had a number of experiences in and when providing care to physically disabled expectant women from ANC, Labour, Emergencies, Post-natal, to Transport. As discussed below

In ANC:

The midwives pointed out that:

"The physically disabled expectant women are easy to continuously monitor on drugs and compliance since most of physically disabled expectant women come for ANC on a routinely basis. However, some of them have no attendants since most of them come alone for ANC. It is very difficult to communicate with them which makes it hard to get the mother's details during ANC". (Key informant 3)

Labour:

The midwives pointed out that:

"It is difficult to explain labour progress to the physically disabled expectant women due lack of corporation. There is case of over screaming. They find it difficult to climb the bed and some of them have poor hygiene". (Key informant 4)

This was confirmed through key informant interviews with technical staff at health facilities (midwives, health in charge)

"The service to cater for disabled expectant women is not well catered for in our health. Labour wards lack special facilities for participants such as adjustable delivery beds and health centres are not easily accessed due to many steps and lack of ramps. Although suggestions have been made on the need to make health care facilities disability friendly, the Ministry of Health has not yet put [this] into consideration" (Key informant5)

Emergencies:

The midwives pointed out that:

"It is difficult to consent and explain the procedures to the physically disabled expectant women. They usually do not accept referral because of fear. There is ignorance of occurrence of a condition such as PPH". (Key informant6)

Post-natal:

The midwives pointed out that:

"These mothers always do not understand return dates for post-natal care which makes them not to come back. Negligence of neonates especially the mentally retarded mothers. Some of them never come back for immunisation. Language barrier also makes counselling difficult". (Key informant7)

Transport:

The midwives pointed out that:

"They always lack family support financially which forces some of them to come on their own using boda-boda. Furthermore, due to the long distances, mothers come late and even miss some services such as early diagnosis of UTIs and post-natal service. In the health facility there are few wheelchairs, stretchers and there are no ramps to help them." (Key informant 8)

The midwives from the health facilities also pointed out that they had challenges when providing care to expectant disabled women in this health Unit such as communication barriers which made it difficult to counsel these mothers, and to explain details during ANC since the government has never trained them on how to handle physically disabled expectant women. One of the midwives pointed out that:

"These mothers need a lot of time to understand what you explain but we have much work to be done compared to time used to help these mothers since the number of midwives are few. The physically disabled expectant women are sometimes rude and they want immediate attention on their arrival. They do not follow the date given but only come when they feel a little bit sick". (Key informant9)

One of the labor suits in charge pointed out that:

"They do not observe hygiene. These mothers' communication is difficult which makes them aggressive. Furthermore, some of these mothers do not come with items for delivery." (Key informant 10)

This was supported by one of the health In-charges that:

“These mothers feel offended when their disability is talked about; most of them are uncooperative and short tempered”. (Key informant 10)

This was further supported by midwives from marumages HC III that:
“There is limited time to offer health talk, inadequate maternal services such as mama kits, and aggressiveness of some mothers, there are limited specialists such as deaf-blind interpreters. She added saying that non-stable operational service for abnormal deliveries” (key informant 7)

How midwives coped with these challenges
The midwives pointed out that:
“We instruct the expectant women with disabilities to come with someone to assist in interpreting the language and at times some interpreters are employed at the health centre although mostly in private health centres.” (Key informant 1,2,8).

Chapter 5: Discussion of Findings

5.1. Discussions of findings

These are the discussions of the major findings as per the objectives on which the researcher based the study.

5.1.1. The health facility readiness in providing quality health care delivery services

According to the findings, we expected at least each facility to have one or more functional devices. However, most of the facilities were reported as lacking functional assistive devices such as deaf-blind interpreters, wheel chairs, talking boards, crutches, adjustable beds and stretchers.

The midwives pointed out that to a small extent the health facilities were ready to receive and treat expectant women with disabilities. They pointed out that the health facilities had facilities such as Labour rooms with climbing blocks, proper lighting, ramps, bathrooms and transportation means.

The above result was supported by health system Oxford (2012) that pointed out that Geographical accessibility of households to health facilities increased from 49% per HSSP to 72% in 2004 as a result of construction of new HCIIs. There has however been a mismatch between construction of new health facilities and capacity to make them functional in terms of human resources, medical equipment, which aids the disabled expectant women to labour services.

This was further supported by WHO (2009) that reported that most health units are usually constrained by lack of appropriate physical facilities such as ramps, adjustable beds especially in labor wards, wheel chairs and disability-friendly sanitation facilities in hospitals. These constraints have also been highlighted by WHO and UNFPA as key health facility barriers to people with disabilities' access to healthcare services.

5.1.2. The challenges faced by disabled expectant women in accessing the delivery services

From the finding it can be noted that despite the desire for childbirth and skilled care, several of the participants in this study reported how their disability, together with a disability-insensitive organization and delivery of skilled care services, and other

constraints, often make it extremely difficult or impossible for them to access and use such services. Although some participants reported a number of positive experiences, for the purposes of this paper, the challenges they encountered in accessing services stratified include poor physical accessibility, language barrier, negative attitudes of health workers and long queues at the health facilities were singled out as the main challenges that physical disabled expectant women face while trying to access SRH services in Soroti. Other challenges included long distances to the health facilities, high costs of services, and the fact that health workers are not experienced to handle physical disabled expectant women or even fear them.

These results were in agreement with WHO (2009) that reported that most health units are usually constrained by workers' attitude, communication barriers, lack of appropriate physical facilities such as ramps, adjustable beds especially in labor wards, wheel chairs and disability-friendly sanitation facilities in hospitals. These constraints have also been highlighted by WHO and UNFPA as key health facility barriers to people with disabilities' access to healthcare services. As seen in the table below. Multiple responses were allowed. This is supported by Wilberforce (2009), who pointed out that poor infrastructure and lack of essential equipment also affected reproductive service delivery. Almost two thirds 60% of health centres lacked examination rooms, 93% lack tables and stools for gynaecological examination, and 53% of the health centres lack delivery rooms, 47% did not have satisfactory toilet facilities. Also 53% of the health centres lack basic equipment for a functional referral system, notably radio transmitters and ambulances. Nearly three quarters (73%) lack reliable sources of water

Furthermore, Shaikh & Hatcher (2005:51) supported it, in that people with disabilities may feel reluctant to access health services although they may have serious health problems that require health service intervention. This is because of their experiences from previous attempts to access health services, particularly the attitudes and perceptions of health care providers. Therefore, patients' ability to accept and utilize services has a relationship with service providers' attitudes (d'Amboise, Abbey & Hussein 2005; Jones *et al*. 2008; Shaikh & Hatcher (2007). This is usually compounded by societal beliefs and expectation that physically disabled expectant women should not conceive at all:

5.1.3. To describe the experience of midwives in providing services to the disabled expectant women in the health facilities

The findings indicated that the midwives' experiences in and when providing care to physically disabled expectant women ranging from ANC, Labour, Emergencies, Post-natal, to Transport. Lack of corporation and communication barriers, which made it difficult to explain labour progress to the physically disabled expectant women.

Furthermore, there were cases of over screening. The mothers inhabited poor hygiene practices, they found it difficult to climb the bed and there was ignorance of occurrence of a condition such as PPH. These mothers always did not understand return dates for post-natal care which made them not to come back. Negligence of neonates especially the mentally retarded mothers. Some of them never come back for immunization.

Furthermore, the midwives from the health facilities had challenges when providing care to expectant disabled women in this health Unit such as communication barriers which made it difficult to counsel these mothers, and to explain details during ANC. Inadequate maternal services such as mama kits, few wheelchairs, stretchers and lack of ramps to help them, they also had no training on how to handle physically expectant mothers. The midwives acknowledged their 'lack of competence, knowledge and skill' regarding disability and felt that, on reflection, their failure to consult and collaborate with disabled women contributed to their failing to provide individualised woman centred care to women with disability which is in agreement with results by WHO, 2009.

Chapter 6: Conclusions and Recommendations

6.0. Conclusions

Health Facility readiness to accommodate expectant women with physical disabilities in Soroti city have the conclusion as per the findings below,

The study revealed that health facilities in Soroti face significant challenges in accommodating physically disabled expectant women including inadequate infrastructure ,lack of accessible equipment and limited staff training .Physically disabled expectant women in Soroti city experience physical and social barriers that hinder their access to the health care services .Midwives also face challenges in providing care due to lack of training and infrastructure upgrading ,staff training ,and accessible services that cater to the unique needs of physically disabled expectant women. Implementing these changes can help promote equitable access to healthcare and reduce disparities in health care delivery. readiness of the health facilities in Soroti City to receive and treat expectant women with disabilities was reported to be inadequate. Most of the health facilities lacked facilities such as ramps, health workers were sometimes rude, lacked interpreters and health workers were not trained to handle physically disabled expectant women.

From the findings, it was also discovered that despite the desire for childbirth and skilled care, several of the participants in this study reported how their disability, together with a disability-insensitive organization and delivery of skilled care services, and other constraints, often make it extremely difficult or impossible for them to access and use such services. Although some participants reported a number of positive experiences, for the purposes of this paper, the challenges they encountered in accessing services included: poor physical accessibility, language barrier, negative attitudes of health workers and long queues at the health facilities were singled out as the main challenges that physical disabled expectant women face while trying to access SRH services in Soroti. Other challenges included long distances to the health facilities, high costs of services, and the fact that health workers are not experienced to handle physical disabled expectant women or even fear them.

The findings also indicated that the midwives had experiences in and when providing care to physically disabled expectant women ranging from ANC, Labour, Emergencies, Post-natal, to Transport. The main challenges faced included: lack of corporation from physically

disabled expectant women and communication barriers, **which** made it difficult to explain labour progress to the physically disabled expectant women.
Furthermore, there were reported cases of over screaming, poor hygiene practices, difficulty in climbing the bed and ignorance of occurrence of a condition such as PPH. These mothers did not understand return dates for post-natal care which made them not to come back. Negligence of neonates especially the mentally retarded mothers. Some of them never come back for immunization.
Furthermore, the midwives from the health facilities had challenges when providing care to expectant disabled women in this health Unit such as communication barriers made it difficult to counsel these mothers, and to explain details during ANC. Other challenges included inadequate maternal services such as mama kits, few wheelchairs, stretchers and lack of ramps to help them, and lack of training on how to handle physically expectant mothers. The midwives acknowledged their 'lack of competence, knowledge and skill' regarding disability and felt that, on reflection, their failure to consult and collaborate with disabled women contributed to their failing to provide individualised woman centred care to women with disability.

6.1. Recommendations

Based on the study findings the researcher had the following recommendations for Soroti City health care facilities;

For Health Care Facilities:

1. **Infrastructure upgrades:**

   For health care facility readiness to accommodate physically disabled expectant women should install ramps, widen doors and corridors and ensure accessible rest rooms and examination rooms and inclusive services like special clinic days

   Accessible equipment:

   Health facility readiness to accommodate physically disabled expectant women should provide adjustable examination tables, accessible medical equipment

   Staff training:

   Health facility readiness to accommodate physically disabled expectant women in Soroti city should have regular training on caring for physically disabled expectant women including disability awareness

2. Equipping health workers with knowledge and skills to enable them adequately address the needs of physically disabled expectant women at health care centres, and to devise alternative interventions to address the plight of physically disabled expectant women. Training institutions and service providers need to be equipped with advanced knowledge and skills of accommodating physically disabled woman who are expectant because human resource is a key in service delivery especially in lower-level health facilities in communities and one of the indicators used for achieving of the same millennium Goals.
3. Raising community awareness on SRH and disability, improving physical access to medical facilities, staff development among medical personnel, and adapting materials to fit persons with disabilities, llike adjustable equipment.

6.2. Limitations of the study

Time limitation and budget constraints

Financial constraints

The health care providers when observed attending to women suit modified their behavior thus introducing bias.

This was a facility-based study and it is possible that there are some people whose opinions we're not obtained because they were not at the health facilities during the time of the study.

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APPENDIX I: Interview guide for midwives

My name is Aanyu Goretti a student of Uganda Christian University Mukono. I am conducting research on the topic: ASSESSMENT OF HEALTH FACILITIES' READINESS TO ACCOMMODATE PHYSICALLY DISABLED PREGNANT WOMEN IN SOROTI CITY, as a partial requirement for the reward of Master's Degree in Public Health Leadership (save the mother's)

You have been selected to participate in this research and therefore requested to share information that can help serve physically disabled pregnant women better.

The information you give shall be confidential and will only be used for the purpose of this research which is purely academic.

Section A: Background Information

Age

a) 22-26 years b .27- 31 years c. 32- 36 years d. 37-40 years e. 41- 45 years f. Above 45 years

Gender

a. Mae b. female

Education level

a. Diploma b. Certificate c. bachelor d. Masters

Marital status

a. Married b. Singe c. widowed d. cohabiting e. divorced

Experience

a. 1-5 years b. 6-10 years c. 11- 15 years d. Above 16 years

Section B: **Assistive devices and disabilities in pregnant women attending the heath facilities**

1. Do physically disabled expectant women use the facility?

   I)Yes

   ii) No

2. If yes, what type of disability have you seen among expectant women?

I) Limb deformities ii) Hearing impairment (deaf) iii) Visual impairment (blind)

iv) Dumb

v). others (specify……………………

2. How many physically disabled expectant women are received monthly?

3. What assistive devices/services are available in this health facility to help physically disabled expectant women to access Maternity services?

1=Available and functional, 2= Available and not functional, 3=Not available

Devices/services	Availability
a) Stretchers	
b) Crutches	
c) Hand railing	
d) Proper lighting	
e) Walking cane sticks	
f) Large doors	
g) Wheel chairs	
h) Talking boards	
i) Sign language interpreters	
j) Deaf-blind interpreters	

v) Have you had any training on care/ helping the physically disabled expectant women?

1. Yes
2. No

Section B: CHALLENGES EXPERIENCED BY PREGNANT WOMEN WITH DISABILITIES

vi) Can you share with me your experience when providing care to physically disabled expectant women? (Probe: ANC, Labour, Emergencies, Post-natal, Transport)

vii) What challenges do you met when providing care to expectant disabled women in this health Unit?

viii) How do you cope with these challenges above?

ix) In your view how would rate the health facility readiness to receive and treat expectant women with disabilities? Suggest areas you would want improved.

Appendix

2: Interview guide for women with physical disabilities

Section A: BACKGROUND INFORMATION.

AGE:

a. 20-25 years b. 26- 30years c. 31- 40 years d. 41 years and above

Level of education

a. Primary b. Secondary c. Certificate d. others

Marital status

a. Married b. Singe c. Widowed d. Cohabiting d. Divorced

Occupation

a. Teacher d. Cleaner c. peasant d. Business e. market vendors' f. Tailors g. Hair dresser
h. craft makers I. bar attendant

Religion

a. Protestant b. Catholic c. Moslem d. Born again e. Others

SECTION B: CHALLENGES FACED BY PREGNANT WOMEN WITH PHYSICAL DISABILITIES

i) How many deliveries have you had?

ii) How old were you when you got disabled?

iii) **D**uring antenatal, delivery and following delivery what was your experience Using the health facilities in view of the fact that you have a disability probe: infrastructure, communication with medical staff, furniture access to different areas

iv) Did you get any challenges resulting from the fact that you were disabled? What challenges did you get?

v) Kindly share with me how midwives received and attended to you in view of the fact that you are physically disabled?

What challenges did you get?

vi) What messages would you want to share in order to encourage women with disabilities to access the health services?

vii). In your view how would you rate the health facility readiness to receive and treat expectant women with disabilities? Suggest areas you would want improve if you are to deliver in the facility again.

Appendix 3: Health Facility Observation Checklist

Use the appropriate response; 1=**Available and functional** **2=Available but not functional** **3=. Not Available**

Item	Available and functional	Available & non functional	Not available
Wheel chairs			
Ramps			
Large doors			
Labour room			
Climbing blocks			
Bathrooms			
Transport			
Labourite			
Ambulance			
Rails			
Stools			
Kitchen			

Laundry			
Stretchers			
Clutches			
Hand railing			
Proper lighting			
Walking canes			
Talking boards			
Interpreters of sign language			
Braille			

Appendix 4: Letter from UCU

UGANDA CHRISTIAN UNIVERSITY

School of Research and Postgraduate Studies

"A Center of Excellence in the Heart of Africa"

Consent Form for Participants

Insert title of project

Consent Form for Participants

ave read the **Information Sheet for Participants** for this study and have had the details of e study explained to me. My questions about the study have been answered to my tisfaction, and I understand that I may ask further questions at any time.

lso understand that I am free to withdraw from the study at any time, or to decline to answer y particular questions in the study. I agree to provide information to the researchers under the nditions of confidentiality set out on the **Information Sheet**.

gree to participate in this study under the conditions set out in the **Information Sheet** form.

gned: ______________________________

ame: ______________________________

ate: ______________________________

esearcher's Name and contact information:
AANYU GORRETI 0772562213 aanyugorreti@yahoo.com

upervisor's Name and contact information:

UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

Noted/ No objection for this health related research to be conducted in the district. In charges of selected facilities are hereby urged to cooperate with the student.

7/6/2017

To Whom It May Concern:

2nd June 2017

Dear Sir/Madam,

Re: **AANYU GORRETI - RS13M07/014**

This is to introduce **Aanyu Gorreti,** who is a post-graduate student in Masters of Public Health Leadership programme at the **Uganda Christian University**, Mukono. This programme is known as the **Save the Mother's** Programme. Professionals from various fields of work and experience are being trained to address the tragedy of maternal death in Uganda.

Gorreti must complete a research project prior to her graduating from the program. Her research project is **"Assessment of Health Facilities Readiness to Accommodate the Physical Disabled Women in Soroti Municipal, Soroti District."**

We would appreciate your facilitation and help for her work and research in maternal health. If you would like a copy of her report at the completion of this work, she will gladly provide that for your reading.

Again many thanks for assisting this excellent student in her endeavours to reduce the number of mothers dying and improve maternal health.

Sincerely,

MMutabazi

Dr. Miriam Mutabazi
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