

**A PRACTICE FRAMEWORK TO IMPROVE
ACCESSIBILITY OF MATERNAL HEALTHCARE
SERVICES FOR WOMEN WITH DISABILITIES IN
KWAZULU-NATAL, SOUTH AFRICA**

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Health Sciences in the Faculty of Health Sciences at the Durban University of
Technology

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Abstract

Background

Access to maternal healthcare services is a challenge in most low and middle-income countries. South Africa is one of the countries striving to improve the accessibility of maternal healthcare services. Although South Africa has put some interventions to improve the accessibility of maternal healthcare services, vulnerable women including women with disabilities are still facing numerous challenges when trying to access maternal healthcare services.

Aim

The aim of the study was to explore the factors that impact access to public maternal healthcare services for women with disabilities in KwaZulu-Natal with the ultimate goal of developing a practice framework to improve women with disabilities' access to maternal healthcare services.

Methodology

An in-depth qualitative study was conducted using the case study method. Interviews and focus group discussions were used to collect data. Twelve women with disabilities (four with physical impairments, four with hearing impairments and four with visual impairments) were interviewed for this study. Focus group discussions were conducted with sixteen midwives and one-on-one interviews were conducted with four gynaecologists and one medical officer. Data were transcribed verbatim and analysed utilising the framework of assessing access to maternal healthcare services by Peters *et al.* 2008: 162.

Findings

Several factors impact access to maternal healthcare services for women with disabilities. They are classified into systemic, infrastructural and personal. These factors are interconnected to either positively or negatively impact access to maternal healthcare services for women with disabilities. Systemic factors include

availability of human resources, training on handling pregnant women with disabilities and availability of sign language interpreters. Infrastructural factors include the design and layout of buildings, adjustable equipment, and assistive devices. Personal factors include attitudes of healthcare workers to pregnant women with disabilities, empowerment amongst women with disabilities, availability of a companion and the ability to read and write.

Key words: Access, disability, maternal health, maternal healthcare services.

Dedication

This study is dedicated to my mother, Talitha Ndhlovu who has been a pillar of strength throughout my educational journey. My dedication also goes to my beloved husband, Gift for his unwavering support and encouragement. He has been there for me from when I started to the time when I completed. He pushed me when he saw that I was almost giving up.

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Glossary of Terms

Access: The ability of the women with disabilities to obtain maternal healthcare services (that is antenatal, obstetric and postnatal care) as well as the maternal health facilities (primary, secondary and tertiary) ability to respond to the needs of women with disabilities.

Disability: Having a physical impairment, a hearing impairment, a visual impairment, or a combination of any of the two impairments, or all of the three impairments.

Maternal health: The health of a woman during pregnancy, childbirth and the postpartum period.

Maternal healthcare services: Services provided to women during pregnancy, childbirth and postpartum care. These include antenatal, childbirth and postpartum services.

List of Acronyms

Acronym	Full word/sentence
AAAQ	Availability, Accessibility, Acceptability and Quality framework
ANC	Antenatal care
AIDS	Acquired Immunodeficiency Syndrome
BMD	Biopsychosocial Model of Disability
CEO	Chief Executive Officer
CHC	Community Healthcare Centre
CRPD	Convention of the Rights of Persons with Disabilities
DUT	Durban University of Technology
DoH	Department of Health
DSD	Department of Social Development
EmOC	Emergency Obstetric Care
ICF	International Classification of Functioning Disability
HRMD	Human Rights Model of Disability
HIV	Human Immunodeficiency Virus
KZN	KwaZulu-Natal
MMD	Medical Model of Disability
PNC	Postnatal care
PHC	Primary Healthcare
SAHRC	South African Human Rights Commission
SDGs	Sustainable Development Goals
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WWD	Women with disabilities

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Disability is an important public health issue in low, middle and high-income countries (Hosseinpour *et al.* 2013: 1282). Evidence shows that the healthcare needs of people with disabilities are generally not adequately met due to structural, financial and attitudinal barriers to access (Shakespeare and Kleine 2013; Maart and Jelsma 2013). Although people with disabilities face challenges in accessing healthcare services, women with disabilities (WWDs) have more challenges compared to their male counterparts. This has been attributed to the fact that WWDs are more likely to be poor, have low education levels and are paid less as compared to men with disabilities (Lawler *et al.* 2013: 205). When it comes to access to maternal healthcare services, WWDs are worse off due to the prevalence of the dominant misconception that they are asexual and thus do not require reproductive healthcare services. Pregnancy and motherhood are considered taboo amongst this population (Schildberger, Zenzmaier and König-Bachmann 2017: 2). Despite the fact that most people with disabilities reside in low and middle-income countries, research on the experiences of WWDs when accessing maternal healthcare services is growing in high-income countries and not in low and middle-income countries (World Health Organization [WHO] 2011: 30).

The South African government is commended for developing and implementing measures to reduce maternal mortality through key policies. These measures seem not to be yielding intended results as the maternal mortality rate is still significantly high (625 deaths per 100 000 live births) (Mulaudzi *et al.* 2016: 4). As such, more efforts need to be channelled towards improving access to quality maternal healthcare services. While maternal healthcare services are free in South Africa, several WWDs are not accessing these services due to lack of transport and other systemic limitations (Sherry 2014; Gichane *et al.* 2017). In order for South Africa to reduce maternal mortality, there is a need to improve access to maternal services, especially for WWDs.

Since South Africa is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the South African government is expected to organise and strengthen healthcare services for WWDs. However, health planners often overlook the needs of people with disabilities and WWDs in particular. The systemic exclusion of WWDs at policy levels results in maternal healthcare services that are inadequately prepared for WWDs (Devkota *et al.* 2018: 16). This systemic exclusion of WWDs from maternal

healthcare services in KwaZulu-Natal (KZN) is alluded to by Mavuso and Maharaj (2015: 86). Their study explored the challenges that are faced by people with disabilities in accessing reproductive health service (Mavuso and Maharaj 2015: 86). It focused on access to reproductive health services for people with disabilities. However, there is a gap for in-depth research on WWDs' access to maternal healthcare services from the perspectives of WWDs and maternal healthcare workers.

The South African White Paper of the Rights of People with Disabilities is more inclined towards the rights-based definitions. The rights-based definition of disability is based on the UNCRPD definition outline in Article 1. According to UNCRPD Article 1, “people with disability include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (United Nation 2006: 4). The South African White Paper then summarises the rights-based definitions as including the following elements:

- Presence of impairment;
- Internal and external limitations or barriers which hinder full and equal participation;
- A focus on the abilities of the person with a disability; and
- Loss or lack of access to opportunities due to environmental barriers and/or negative perceptions and attitudes of society (South Africa 2015: 17).

1.2 PROBLEM STATEMENT

The government of South Africa enshrined equality in Section 9 of the Bill of Rights (South Africa 1996: 5-6). Article 3 of Section 9 states that “the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth” (South Africa 1996: 6). Non-discrimination of people with disabilities is further emphasised by the South Africa White Paper on the Rights of Persons with Disabilities (2015: 4) which has its vision as, “South Africa: A free and just society inclusive of all persons with disabilities as equal citizens”. Furthermore, Section 27 of the South African Constitution recognises access to health as a human right (South Africa 1996: 11).

Although there is strong political commitment on the part of the South African government to address inequalities and discrimination faced by people with disabilities, there is still a gap between policies and their implementation (Salooje *et al.* 2006: 231). For instance, the government introduced the free healthcare policy for pregnant women and children under the age of six in 2002 (Coovadia *et al.* 2009: 1820), which was then extended to people with disabilities in 2004 (Salooje *et al.* 2006: 231). However, a considerable proportion of the exempted groups still pay to utilise services (Harris *et al.* 2011). This has resulted in access to healthcare services being a challenge to the larger portion of the population from disadvantaged groups in South Africa. Because a significant proportion of the population of disadvantaged groups have challenges in access to healthcare service, Marten *et al.* (2014: 2168) conclude that the South African health system “falls short in provision of equitable access to needed, effective healthcare”. Although access barriers are prevalent in South Africa, they are not well understood (Schnieder *et al.* 2012: 8). Furthermore, the increased public awareness of disability issues and rights, is not translating into more research in terms of access to healthcare for people with disabilities especially maternal healthcare services for WWDs.

Findings from a few studies available indicate that people with disabilities face numerous challenges in accessing healthcare services (Sherry 2014: 91). The plight of WWDs is worse off than that of men with disabilities. Public maternal healthcare services are not adequately prepared to cater for WWDs (Mavuso and Maharaj 2015: 84). “While the factors that militate against access to such services for women, in general, are well- documented in South Africa, there is little research that documents the factors that inhibit or enhance access to maternal healthcare services for WWDs” (Mohamed and Shefer 2015: 3). There is a need, therefore, to unpack the factors that impact access to maternal services for WWDs. This study, therefore, sought to explore the factors that impact access to maternal healthcare services for WWDs in the province of KZN.

1.3 AIM OF THE STUDY

The aim of the study was to explore the factors that impact access to public maternal healthcare services for WWDs in KZN with the ultimate goal of developing a practice framework to improve WWDs’ access to maternal healthcare services.

1.4 OBJECTIVES OF THE STUDY

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 service for women with disabilities.
- Explore the facilitators of access to maternal healthcare service for women with disabilities.
- Describe how access to maternal healthcare services by women with disabilities can be improved.

1.5 RESEARCH QUESTIONS

The study was guided by the following questions:

- What are the practices of maternal healthcare service providers in providing service to women with disabilities?
- What are the perceptions of maternal healthcare service providers with regard to access to maternal healthcare services for women with disabilities?
- What are the perceptions of women with disabilities with regard to access to maternal healthcare services?
- What would improve access to maternal healthcare services for women with disabilities?

1.6 SIGNIFICANCE OF THE STUDY

As the Sustainable Development Goals (SDGs) emphasise equitable access to healthcare services, there is a need especially in low- and middle-income countries to generate evidence of the lived experiences of WWDs seeking maternal healthcare services. Equity emphasises the addressing of the specific barriers that exist for different service users (Eide *et al.* 2011: 12). This study is important as it focused on WWDs who are an essential group that requires attention, especially in the face of equitable access, reduction of maternal mortality and eradication of mother to child HIV infection.

The findings of this study will not only contribute towards the understanding of what WWDs face in accessing and using maternal healthcare services but also help in providing the healthcare system, policy makers, and maternal healthcare service providers of the different countries to take necessary remedial actions

to redress the situation. Vergunst et al. (2015: 2) articulate this when they say that the specific information on access to healthcare for people with disabilities is essential in the development of interventions that will improve the lives of people with disabilities. Therefore, this study will be valuable to the stakeholders involved in the provision of maternal healthcare services, policy makers involved in maternal health services as well as stakeholders advocating for equity of access and health systems strengthening.

Globally, health systems are striving towards universal access to reproductive healthcare services including maternal healthcare services (Alkenbrack *et al.* 2015: 3). Therefore, it is necessary to explore the maternal healthcare needs, barriers and facilitators of access to maternal services for WWDs and develop a practice framework to improve access to maternal services for WWDs, especially in low- and middle-income countries. This study is important as it provides a practice framework for improving accessibility of maternal healthcare services for WWDs in KZN. The importance of a practice framework specifically for WWDs is emphasised by Mitra *et al.* (2015: 500) when they say one approach to systematically address disparities in access to maternal healthcare services for WWDs, is to utilise a framework that considers the barriers to maternal healthcare services that are specific to WWDs.

This explorative study helps to better understand the experiences of WWDs in accessing maternal healthcare services in KZN. Its contribution comes against the backdrop of limited research conducted on this specific population. Findings of such an explorative study are of interest to researchers as they assist in the identification of gaps in the research on access to maternal healthcare services for WWDs. The study thus helps in informed and strategic decision making by enhancing the understanding of access to perinatal healthcare services for WWDs.

1.7 STRUCTURE OF THE THESIS

This thesis is presented in eight chapters that are presented as outlined in Table 1.1 below.

Table 1.1: Structure of the thesis

Chapter	Title	Content Description
1	Orientation to the study.	This chapter presents the background to the study, problem statement, the aim of the study, research questions and objectives of the study.
2	Literature review.	Chapter 2 presents the review of relevant literature to the study.
3	Conceptual framework.	This chapter provides and explains the conceptual framework for the study.
4	Research design and methodology.	Chapter 4 presents the research design and methods of data collection and analysis.
5	Presentation of findings.	This chapter presents the findings of the study that emerged after the process of data analysis.
6	Discussion of findings.	Literature that either supports or refutes the findings is discussed in this chapter.
7	A practice framework to improve accessibility of maternal healthcare services for WWDs.	A practice framework to improve accessibility of maternal healthcare services for WWDs is presented in this chapter.
8	Summary, limitations, recommendations and conclusion of the study.	This chapter concludes the research and presents recommendations.

1.8 SUMMARY OF THE CHAPTER

This chapter provided the background of the study. It discussed how access to maternal healthcare services is important for WWDs. The problem statement shows why it is important to understand how WWDs experience maternal healthcare services. The main purpose of the study is to develop a framework to improve accessibility of maternal health services for WWDs. The next chapter is a literature review showing the gaps in terms of access to maternal services for WWDs.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is an integral part of research. Hart (2001: 13) defines it as “the selection of available documents (both published and unpublished) on the topic which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and effective evaluation of documents in relation to the research being proposed”. In this chapter, the researcher examined existing research on WWDs’ access to maternal healthcare services with the aim of identifying the gaps that exist in the existing literature. This chapter therefore discusses the literature that helped in framing the problem of the study (Creswell 2014: 26). In addition, the literature review enabled the researcher to develop the research questions that guided the study as well as the choice of the research method. The literature was discussed in relation to the definition of disability, models of disability, access to healthcare services for WWDs and access to maternal healthcare services.

2.2 PROCESS OF REVIEWING THE LITERATURE

The literature review for this study was an iterative process which enabled the researcher to keep abreast with the latest research developments in access to maternal healthcare services for WWDs. Literature was searched using the Durban University of Technology (DUT) eLibrary. Key search terms included WWDs or disabled women or women with impairments and access and maternal healthcare services, or childbirth services, pregnancy, delivery and postpartum services. The search was also conducted on independent databases that included EBCOHOST, PROQUEST, CINAHL and Google Scholar. The identified articles were stored in the Endnote library.

2.3 WOMEN WITH DISABILITIES

According to the WHO’s report on disabilities, WWDs make up 10% of the total global population (WHO 2011: 29). Furthermore, WWDs represent 19.2% of the women globally (WHO 2011: 30). In addition, WWDs make up three quarters of the population of people with disabilities in the low- and middle-income countries (WHO 2011: 28). Furthermore, WWDs are more likely to be poor, have low education levels and likely to be paid less as compared to men with disabilities and other women in general (Lawler *et al.* 2013; WHO and UNFPA 2009). All the above-mentioned facts indicate that WWDs are a significant population whose rights need to be recognised, especially their sexual reproductive health rights.

Women's reproductive age group is 15-49 years (WHO 2011: 9). However, anyone under 18 years is considered a child and therefore requires consent from the parents and ascent from the child (Greig *et al.* 2007; Tisdall *et al.* 2009). Because of the challenges regarding the consent from children under 18, in this study, WWDs will refer to women who are 18-45 years. As finding pregnant WWDs was envisaged a challenge, this study included women who were pregnant as well as those who had been pregnant in the previous five years. The five-year period was selected as research indicated that pregnancy and childbirth is an emotional process that a woman is able to remember vividly even after five years (Takehara *et al.* 2014: 7).

Pregnancy and delivery are challenges to all women worldwide. This is evidenced by the fact that many women die during pregnancy and childbirth (Mgawadere *et al.* 2017: 4). For WWDs, pregnancy and delivery pose more challenges as the impairments may result in further complications (Signore *et al.* 2011; Lawler *et al.* 2013; Lim 2015). While some of the complications are as a result of the impairments which may interact with the pregnancy to pose more risk for the WWDs, other challenges are context-based and created by the society and the people who work with pregnant WWDs (Barber 2008: 330). When impairments interact with disabilities to result in a complication, WWDs require integrated services and individual care to attend to both the pregnancy and the impact of the impairment (Lawler *et al.* 2013: 213). However, such individual care and integration of different services to assist pregnant WWDs usually lack (Mitra *et al.* 2016: 8).

Despite research indicating that more WWDs are becoming pregnant and delivering healthy babies (Redshaw *et al.* 2013: 78), current maternal healthcare services are fraught with numerous challenges that militate against easy access of healthcare services for pregnant WWDs. (Ledger *et al.* 2016: 10). In order to understand how disability is being conceptualised in terms of access to maternal healthcare services for WWDs, it is important to discuss the different definitions and models of disability. Different models and definitions of disability are crucial as they shape psychological, political and economic outcomes of disability (Smart 2009; Dirth and Branscombe 2017).

2.4 THEORETICAL UNDERSTANDING OF DISABILITY IN WOMEN WITH DISABILITIES

Although disability is an important public health issue globally, it is a complex phenomenon which does not have a single definition. Different organisations and different countries have different definitions and models which are dependent upon the purpose of the definition or the model. The variances in the definition of

disability have resulted in the differences in the statistical reports on the prevalence of disability nationally and globally (Grönvik 2007: 34). The concept ‘disability’ has undergone evolution as the society’s perception of disability changes. In order to understand who the WWDs are, there is a need to discuss what disability is.

The definition of disability is highly contested. Different criteria are used to define disability depending on the purpose of the definition. This has led to differences on reporting the extent of the prevalence of disabilities within a country. According to Grönvik (2007: 34), there are five common theoretical definitions of disabilities; these include subjective definitions, administrative definitions, functional definitions, relative or environmental definitions and social definitions. The functional definition focuses mainly on the person’s functional limitation, for example, moving difficulties, loss of sight or hearing. It forms the basis of the medical model of disability. According to the Medical Model of Disability, impairments and the effects of the impairments on one’s capacity to perform in daily life are the basis of understanding disability (Molden and Tossebro 2012: 340).

The second definition is known as relative or environmental definition. This definition perceives disability as an interaction between a person and his or her environment. According the Grönvik (2007: 38), the third definition of disability is the social definition of disability. This definition perceives a disability as a result of structural and cultural barriers. The fourth definition is the subjective definition whereby an individual conceives himself or herself as having an impairment and voluntarily includes himself or herself in this category. Lastly, the administrative definition originates from the distribution of welfare support from the state depending on their disability (Grönvik 2007: 38). For example, the South African government through the Department of Social provides a disability allowance and some assistive devices to people with disabilities. These people have to fulfil the criteria set by the Department of Social Development (DSD). Below is a table summarising the five definitions of disability. Grönvik (2007: 38) outlines the five different definitions of disability, and also acknowledges that there are several other definitions which are used for different purposes. Grönvik’s definitions of disability can be summed up as tabulated below.

Table 2.1: Different definitions of disability, their criteria, purposes and agents

Type of definition	Criteria	Purposes and example	Agents
Functional definition	Disability as a lack of or restrictions of bodily functions	“Head-counting” in surveys and censuses, assess need for rehabilitation, training, equipment	Statistical bureaus and medical professions
Relative definition	Disability appears in the relation between a person with impairment(s) and inaccessible surroundings.	Turn the gaze from solely depicting individuals as disabled to the relationship between individuals and surroundings.	Disability movement and policy makers
Social Model of Disability	Disability is the oppression and a barrier against people with impairments.	Turn the gaze from individuals to barriers and oppressive processes within the society.	Disability Movement
Administrative definition	Disabled people are those categorised by the welfare state as needing/or eligible for certain support systems.	Delimit categories of people eligible for certain benefits and supports.	Welfare authorities
Subjective definition	People perceiving themselves as disabled, irrespective of the basis of such perceptions.	Identity construction, filter question in censuses and surveys.	Disability movement

Source: Grönvik (2007: 35).

Different organisations and institutions have also come up with different definitions of disabilities. The WHO International Classification of Functioning Disability (ICF) defines disabilities as an umbrella term, covering impairments, activity limitations, and participation restrictions (WHO 2001: 213). The ICF further differentiates between an impairment, activity restriction and participation restriction. According to the ICF, “an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations” (WHO 2001; Saleeby 2016). This definition is aligned to the Social Model of disability as it explains that disability is caused by the negative interaction of a person with an impairment or health condition with social, economic environmental and personal barriers. The ICF therefore denotes that if the barriers are removed then the person with an impairment or health condition will effectively participate in the society.

The Convention on the Rights of Persons with Disabilities (CRPD) defines people with disabilities as “people who have long term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder their full effective participation in society” (United Nation 2006: 4). This definition is inclined towards the human rights model of disability. According to Degener (2016: 1), the CRPD is the first human rights instrument to recognise that people with disability are right holders and that the impairments cannot be used as a justification to deny the people with disabilities their rights. The South African government ratified the CRPD and the South African Constitution enshrines human rights and equality in the treatment of individuals.

The way in which a given community defines disability will determine the way in which the people with disabilities are perceived, the manner in which the healthcare system is organised to cater for the people with disabilities and the healthcare policies that are in place. Furthermore, how healthcare workers define especially WWDs will determine the way they relate and treat them when they are seeking maternal healthcare services (Sharby *et al.* 2015: 3316). The different definitions of disabilities are articulated in the different models of disability.

2.5 MODELS OF DISABILITY

As the society's views on people with disabilities evolved, different models of disabilities were developed to incorporate the new views of disability. The models expand on the definitions to provide an analytical frame with which to assess where disability comes from, how it can be dealt with and the implications to the society and community (Dirth and Branscombe 2017: 414). They are crucial as “they shape psychological, political and economic outcomes of disability” (Dirth and Branscombe 2017: 415). The different models influence the action that is undertaken and considered to be appropriate in terms of eliminating both the causes and the effects of disabilities. However, there is no single model that can explain every aspect of disability experience because disability is a complex phenomenon (Smart 2009:4). Nevertheless, each disability model when accepted by the maternal health providers will shape the way the maternal health services are organised and interactions between the healthcare workers and the WWDs requiring maternal healthcare services. This section discusses the medical model, social model, biosocial model and the human rights model.

2.5.1 The Medical Model of Disability

The Medical Model of Disability (MMD) emphasises that disability is an individual's problem that requires medical interventions to be treated. It has resulted in healthcare workers focussing on the impairment rather than the person and consequently perceiving the individual as incapable of performing normal activities (Barber 2008: 330-331). The model is more inclined towards the functional definition of disabilities where people with disabilities are perceived as unable to perform certain functions because of the impairment or medical condition. Through the MMD, disability is seen as a problem rather than a way of being; it is viewed as a phenomenon that diminishes the quality of life as opposed to a condition that changes a person's life style. Through this model, people with disabilities are perceived as in need of bio-medical interventions and rehabilitation (Dirth and Branscombe 2017: 415). Furthermore, healthcare workers are seen as central to the decision-making process for people with disabilities thereby disempowering the people with disabilities. The MMD has been dominant in shaping the public perception and attitude toward disability (Smart 2006: 4).

As a result of the MMD, WWDs have been viewed as asexual and not capable of delivering healthy babies. This has resulted in some WWDs being subjected to hysterectomy (WHO 2011:4). Furthermore, when WWDs become pregnant, they are offered opportunities to terminate their pregnancies, if not, they are referred to high care institutions as they are viewed as high risk which may not be the case in some instances (Smeltzer 2007: 96). Earle and Church (2004: 34) cite Symore (1998: 69) as saying, "In the cult of maternity, a woman with a damaged body, it seems, cannot also be a mother. New life cannot issue from such a body. If it is assumed that the body is unable to perform the obligatory mothering rituals required by our society, then it follows that the woman should not bear a child". Although this way of thinking has been challenged by the theorists who view disability as contextual, the attitudes of the communities and some healthcare workers still reflect the MMD's way of thinking.

2.5.2 Social Model of Disability

The Social Model of Disability (SMD) focuses on the needs of the people with disabilities rather than the impairment or the health condition (Byrnes and Hickey 2016: 504). From the perspective of the SMD, it is the environment that is ill prepared for people with impairments that has a disabling effect on the WWDs (Barnes and Mercer 2005; Dirth and Branscombe 2017). The SMD distinguishes impairment from disability. An impairment is defined as a functional limitation of the body while disability is viewed as the structural restrictions or barriers caused by society thereby excluding people with disabilities from mainstream activities

(WHO 2001: 10). According to the SMD, many people with disabilities are healthy and can be included in the mainstream activities. Therefore, WWDs also require the healthcare professionals to assist them to have healthy pregnancies and deliver healthy babies (Byrnes and Hickey 2016: 505). In order to support WWDs, there is a need for modification of structural and attitudinal barriers that are created by society. For example, emphasis is on providing maternal healthcare services that are accessible to all by providing wheelchair- friendly facilities, assistive devices, accessible equipment such as beds and scales and, maternal healthcare workers who are knowledgeable and skilled to provide services to pregnant WWDs.

The SMD is more inclined towards the relative definition of disability as well as the Welfare Model of Disability (WMD). Both the Social Model of Disability (SMD) and the Traditional Medical Model of Disability (TMD) were perceived to have some shortcomings by some theorists who indicated that both the impairment and the contextual factors are intertwined to result in disabling the people with an impairment or a health condition. This is clearly articulated by Barber (2008: 331) who states that, despite the removal of contextual and environmental barriers, it is important to also recognise that the impairments may interact with the pregnancy resulting in some special needs required to ensure that the women with an impairment have a successful pregnancy and childbirth process. The recognition of the interaction between the impairment and the contextual or environmental factors resulted in the development of an integrated model.

2.5.3 Biopsychosocial Model of Disability

The Biopsychosocial Model of Disability (BMD) bridges the two previously described models of disability (MMD and SMD). According to Smeltzer (2007: 193), the BMD perceives disability as arising from physical or biological, emotional, individual and environmental levels. The Biopsychosocial Model of Disability (BMD) is clearly outlined by the Integrated Model of Disability (IMD) developed by WHO known as International Classification of Functioning disability and health (ICF) (Mitra and Shakespeare 2019: 164). The ICF defines disability as “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (WHO 2001: 213).

The shortcoming of the BMD is that it does not have effective tools by which “to assess the disabling tendencies of the government policies and practices, and the physical environments and cultural contexts” (Baylies 2002: 730). As a result, the

medical component of the model seems to dominate more than the social aspect. This is illustrated in Figure 1 below, where disability is portrayed as starting with a health condition which is likely to lead to an impairment “which in turn results in activity limitations and participation restrictions all influenced by contextual factors” (Saleeby 2016: 2). Portraying disability as resulting from a health condition means that disability is still being perceived as a health condition that requires medical intervention to be rectified. In terms of maternal healthcare services, it means the healthcare workers will see the impairment first and then the woman with a disability (Smeltzer 2007: 3).

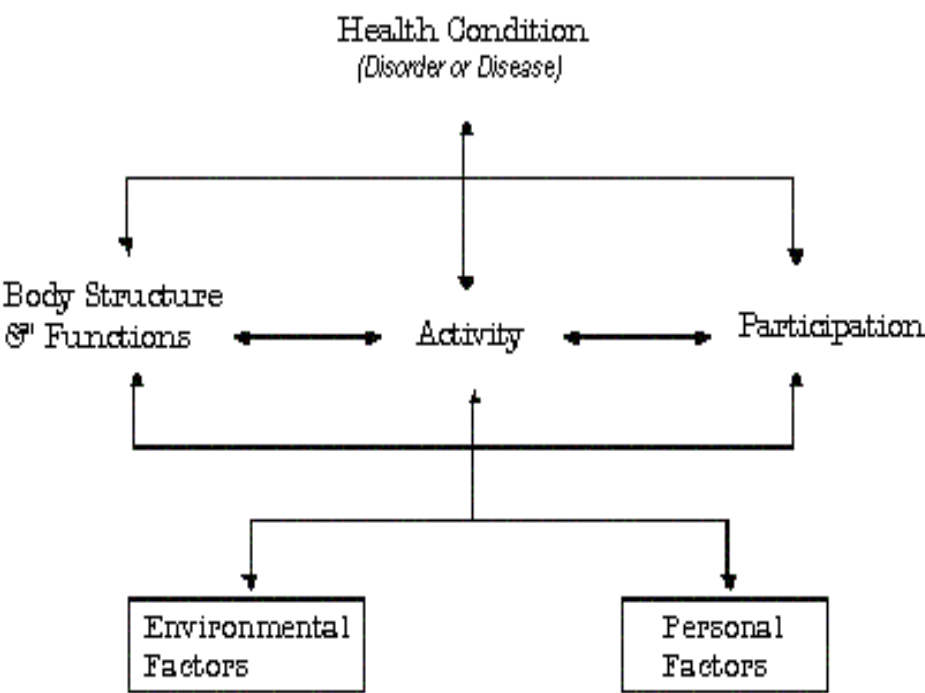


Figure 2.1: Interaction between components of the International Classification of Functioning, Disability and Health

Source: WHO 2001: 18

2.5.4 Human Rights Model of Disability

Globally, there is a move to view disability as a human rights issue. The realisation that disability issues are often not included in human rights discussions led to the conceptualisation of United Nations Convention on the Rights of People with Disabilities (CRPD). Through the CRPD, member states have been mandated to make provisions of ensuring that the rights of people with disabilities are realised. Therefore, the Human Rights Model of Disability (HRMD) emphasises the need for a change in the policies and laws to be inclusive of people with disabilities. The recognition of the importance of rights of people with disabilities has also resulted in a shift of the perception of marriage, pregnancy and childbirth. This is clearly articulated by May and Simpson (2003: 38) who state that, “a clear movement can

be discerned in which marriage, sexual relations and, more recently, parenthood amongst people with disabilities have gone from being absolutely forbidden to being accepted as a right". In addition, there are a variety of international instruments addressing the rights of people with disabilities that affirm commitment to realising these rights. For instance, governments are requested to "report on measures taken to ensure that disabled women have equal access to health services" (Elliot, Utyasheva and Zack 2009: 33).

Although there are different definitions and models of disabilities, all the definitions indicate that for a person to be regarded as someone with a disability, they should have an impairment. Impairment refers to "any loss or abnormality of psychological, physiological, or anatomical structure or function" (WHO 2001: 1047). The WHO report further explains that in the context of health disability, it refers to "any restriction or lack of ability to perform an activity in the range considered to be normal for a human being as a result of an impairment". There are different types of impairments which can result in a disability. These impairments include, visual, hearing, speech, mental and orthopedic (Byrnes and Hickey 2016: 506). In this research, WWDs were interviewed to share their experiences in accessing maternal healthcare services. Considering ethical issues regarding research amongst the population of WWDs with other impairments, this study considered WWDs to be women with visual, physical and hearing impairments.

2.6 WOMEN WITH DISABILITIES' ACCESS TO MATERNAL HEALTHCARE SERVICES

2.6.1 Definition of access

Although access to healthcare services is central to performance of health systems, it is a complex phenomenon which does not have a single definition (Levesque, Harris and Russel 2013: 181). There have been clarion calls for urgent attention to the issue of healthcare access for people with disabilities in low- and middle-income countries (Tomlinson *et al.* 2009: 376). Access to maternal healthcare services is essential as it leads to the reduction of maternal mortality and morbidity. While some authors define access as "the ability to use the healthcare services when needed" (Aday and Anderson 1974: 34), other authors perceive access to be "the degree of fit between the healthcare systems and the expectations of the users of the health systems" (Pechansky 1977: 65) cited in McIntyre, Thiede and Birch (2009: 159). Due to the complexity of defining access, most authors describe access as multi-dimensional and comprising different elements (Ataguba, Akazili and McIntyre 2011: 1). Although different authors tend

to vary on the elements, they seem to agree on the availability, affordability and acceptability elements.

Some authors differentiate between access and accessibility. “While access focuses on the individual’s ability of the population to obtain appropriate services, accessibility refers to the ability of the healthcare service or system to respond to the needs of the population” (Davy *et al.* 2016: 164). Both aspects ‘access’ and ‘accessibility’ are important to ensure that WWDs obtain the quality maternal healthcare services that they need. The current study describes the accessibility of maternal healthcare services for WWDs in public hospitals. In this study, accessibility refers to the ability of the WWDs to obtain maternal healthcare services (that is antenatal, obstetric and postnatal care) as well as the maternal health facilities (primary, secondary and tertiary) ability to respond to the needs of WWDs.

Although there is little research that focuses on healthcare access for WWDs in low- and middle-income countries, existing research indicates that access to healthcare services is marred by lack of health insurance, high cost of transport and in the rural areas poor drug supply, lack of referral and long waiting times (Ahumuza *et al.* 2014; Morrison *et al.* 2014; Sherry 2014; Ganle *et al.* 2016). South Africa is one of the low- and middle-income countries, where research highlights that people with disabilities contend with the lack of adequate communication, poverty and the high cost of transport (Grut *et al.* 2012; McKenzie 2013; Sherry 2014). This is against the backdrop “South Africa represents a classic example of the inverse care law; the lowest socioeconomic groups bear the largest burden of ill-health but have the lowest level of health service utilisation and derive the least benefits from service use” (Ataguba, Akazili and McIntyre. 2011: 67).

The National Department of Health in South Africa has put interventions to improve access to maternal services, quality of maternal services and access to healthcare services for WWDs. These interventions include free maternal healthcare for pregnant women, children under five and people with disabilities, and introduction of district-based specialist teams. The impact of these interventions on WWDs has not been explored as there is little research on how WWDs access maternal healthcare services. Furthermore, there has been an urgent call for research to explore healthcare access amongst vulnerable populations including WWDs (Tomlinson *et al.* 2009: 1861).

2.6.2 Maternal healthcare services

Kifle *et al.* (2017: 7) define maternal healthcare services as “services provided to women during pregnancy, childbirth and postpartum care”. They further define maternal health as “the health of women during pregnancy childbirth and postpartum period”. They further define maternal healthcare services as “antenatal services (ANC), delivery care and post-natal care (PNC)”. The aim of maternal healthcare services is “to reduce maternal mortality by ensuring that women remain healthy throughout pregnancy, deliver safely and recover safely after delivery” (Nnebue *et al.* 2016: 45). These services should be accessible to any pregnant woman.

According to the WHO, approximately 289 000 women died in 2013 because of preventable causes related to pregnancy and childbirth (WHO 2015: 5). Almost 99% of these deaths occur in low- and middle-income countries. The sub-Saharan Africa region contributes more than 50% to these deaths (WHO 2019: 15). Callister and Edwards (2017: 57) identify the following factors as drivers of maternal mortality; poverty and limited access to healthcare services, healthcare workers who lack knowledge of the risk factors, signs and symptoms of complications and traditional health seeking behaviours and disrespect (Callister and Edwards 2017: 57). Most authors agree that most maternal deaths are caused by lack of access to healthcare services particularly emergency services during pregnancy, childbirth and immediate post-partum (Filippi *et al.* 2016; Hanson *et al.* 2017).

According to Rao (2015: 1), the high maternal mortality has received global attention such that one of the targets of the SDGs is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births by 2030. Rao (2015: 1) further states that access to quality maternal healthcare services is one of the interventions that could reduce maternal mortality and morbidity. Women with disabilities face multiple challenges in that they are women, and most likely to be poor and have a disability. Even though maternal services are a priority globally, “existing perinatal healthcare frameworks do not address the needs and barriers faced by WWDs around pregnancy, childbirth and immediate post-partum” (Mitra *et al.* 2015: 499). For example, maternal healthcare is an important element of primary healthcare (PHC). The emphasis of PHC is on caring for vulnerable groups which include women and children. However, most PHC facilities are not adequately equipped to handle WWDs. It is thus imperative that perinatal health frameworks include maternal healthcare needs of WWDs (Byrnes and Hickey 2016: 506).

While WWDs are a significant population that requires attention in sub-Saharan Africa, there is little evidence that documents their experiences in accessing maternal healthcare services (Ahumuza *et al.* 2014; Bremer, Cockburn and Ruth 2010; Ganle 2016; Gichane *et al.* 2017). Some of the few studies available focus on women with a particular disability, for example, a study by Gichane *et al.* (2017: 434-439) only focuses on deaf women. This lack of evidence on the pregnancy and maternity healthcare services for WWDs may result in their needs being largely ignored in the targeted programs and policies that can improve maternal and childbirth services (Gichane *et al.* 2017: 435). While evidence from high-income countries indicates that fragmented services for WWDs requiring maternal healthcare services impact negatively on access to maternal healthcare services for WWDs, the few studies available in sub-Saharan Africa indicate that the structural and attitudinal barriers to access are prominent (Ahumuza *et al.* 2014; Smith *et al.* 2004). The structural and attitudinal barriers are attributed to the health systems of sub-Saharan Africa that are inadequately prepared to handle WWDs requiring maternal healthcare services (WHO 2011: 4).

In South Africa, maternal healthcare services are provided at different levels of care. Each level of care is mandated to provide a certain package of care. These levels of care include first level (clinic, community health centre and district hospital), second level (regional hospital), third level (tertiary) and fourth level (central hospitals) (South Africa 2020: 19). Since maternal health coverage is approximately 90%, there is a likelihood that many WWDs are part of the 10% that is not covered (UNICEF 2012: 11). It is important to explore the challenges that WWDs experience in accessing maternal healthcare services at each level.

2.7 GLOBAL CONTEXT

Globally, a significant progress in the reduction of maternal mortality has been realised in the period between 1990 and 2015 (Kassebaum 2016: 1780). The reduction of maternal mortality is attributed to increased access to skilled birth attendance. UNCRPD has specific provisions that recognise the reproductive health rights of people with disabilities. Article 23 of the UNCRPD enshrines the right of people with disabilities to access sexual reproductive health information and services (United Nations 2006: 15). Despite the fact that many countries (high-, low- and middle-income) are signatories to UNCRPD, existing literature indicates that WWDs have challenges in accessing maternal healthcare services (Redshaw *et al.* 2013: 175). This implies that there is still a long way to ensure equitable access to maternal services.

The long-standing belief that WWDs are asexual and are not strong enough to handle pregnancy and care for their babies is still common in the provision of maternal healthcare services (Ahumuza *et al.* 2014; Ganle *et al.* 2016; Rugoho and Maphosa 2017; Schildberger, Zenzmaier and KonigBachmann 2017). As a result, there has been a systemic exclusion of WWDs at policy level. The exclusion of WWDs can also be noted in healthcare systems that are inadequately prepared to save WWDs. Healthcare workers portray negative attitudes towards pregnant WWDs and have inadequate knowledge to handle pregnant WWDs. Healthcare facilities lack adjustable beds, scales and sign language interpreters to assist WWDs (WHO, 2011; Lawler *et al.* 2013; Høglund 2012; Devkota *et al.* 2017; Devkota *et al.* 2018). For example, one study revealed that people with disabilities were twice as likely to find healthcare provider skills and equipment that inadequately meet their needs and three times as likely to be treated badly by the healthcare providers (WHO 2011: 102). Another study conducted in Timor-Leste, Australia, found out that there is limited visible, prioritisation of disability in health policies centralised decision making in the ministry of health, lack of data on disability, limited knowledge and training of service providers regarding disability and the number and distribution of staff (Ledger *et al.* 2016: 10).

Furthermore, there are conflicting results in terms of studies that explored access to maternal healthcare services. One study conducted in Sierra Leone indicates that there is no significant difference in terms of accessing services between WWDs and women without disabilities (Trani *et al.* 2011: 1479). Other studies reveal that WWDs were more satisfied with antenatal care than the care that they got during labour and postnatal (Morrison *et al.* 2014; Redshaw *et al.* 2013). There is thus need for more research on the experiences of WWDs during pregnancy, childbirth and early motherhood with emphasis on the models of maternity care, effect of the environment as well as the knowledge, attitudes of health professionals towards WWDs (Lawler *et al.* 2013: 215).

Whilst there is a growing body of literature on pregnant women's experiences in accessing maternal healthcare services in the high-income countries, there is a paucity of research in low- and middle-income countries (Ganle *et al.* 2016 and Morrison *et al.* 2014). While studies from high-income countries highlight that WWDs encounter challenges of fragmented services, negative attitudes of healthcare workers and lack of knowledge among the healthcare workers, studies from low-income countries also add the structural barriers such as lack of ramps, inaccessible buildings and lack of transport (Bremer Cockburn and Ruth 2010; Mavuso and Maharaj 2015; Devkota *et al.* 2017; Devkota *et al.* 2018). In addition, studies in low- and middle-income countries also reveal that WWDs will prefer using private healthcare services because of poor quality services in the public

healthcare services especially, the lower levels of care (Mavuso and Maharaj 2015; Devkota *et al.* 2018).

2.8 AFRICAN CONTEXT

Maternal healthcare is a challenge in sub-Saharan Africa as indicated by the fact that maternal mortality rates in this region are still much higher than the global rates. In 2015, the maternal mortality was more than double the global region and the high maternal mortality rates are attributed to inadequate maternal healthcare services and poor-quality maternal healthcare services (WHO 2015: 22). This is so especially for vulnerable populations that include WWDs (Smith *et al.* 2004; Bremer Cockburn and Ruth: 2010 and Gichane *et al.* 2017).

There is little evidence that documents WWDs experiences in accessing maternal healthcare services (Ahumuza *et al.* 2014, Bremer Cockburn and Ruth. 2010, Ganle, 2016, Gichane 2017). However, some of these few studies available focus on women with a particular disability, for example, a South African study by Gichane *et al.* (2017: 434-439) focuses on deaf women only. This lack of evidence on the pregnancy and maternity healthcare services for WWDs may result in the WWDs' needs being largely ignored in the targeted programs and policies that can improve maternal and childbirth services (Gichane *et al.* 2017: 435).

2.9 SOUTH AFRICAN CONTEXT

Section 27 of the Constitution and Bill of Rights of South Africa emphasises equality to women and the right to access reproductive health services (South Africa 1996: 13). This instrument (Constitution) gives women the right to accessible healthcare during pregnancy and labour. Furthermore, the South African government is a signatory to the United Nations Standard on the Equalisation of Opportunities that girls and boys and WWDs should exercise the same rights and obligations other members of the society (McClain 2002: 23). While South Africa is striving for equity in access, little attention has been given to disability. However, research indicates that people with disabilities in South Africa have worse challenges in accessing healthcare services as compared to their non-disabled counterparts (Sherry 2014: 9). Sherry (2014: 9) further argues that access challenges for people with disabilities in South Africa include environmental, transport and cost as well as systemic limitations which include programme design, lack of knowledge, and skills in working with disability.

Since South Africa is a signatory to UNCRPD, the South African government is expected to organise and strengthen healthcare services for WWDs. In addition, “disability, is one of the seven focus areas identified by the South African Human

Rights Commission (SAHRC) within its mandate to promote, protect, and monitor the realisation of human rights in South Africa” (South Africa 2015: 38). However, health planners often overlook the needs of people with disabilities, especially WWDs. This can be attributed to the fact that South African communities view people with disabilities as not having enough stamina to start or be involved in any meaningful sexual relations (Rugoho and Maphosa 2017: 3).

The prevalence of disability in South Africa is contentious as there is no single definition agreed upon. Furthermore, the prevalence of disability in South Africa is determined by disability prevalence surveys which are based on reported disability often by a proxy informant which may overestimate or underestimate the prevalence. According to the Statistics South Africa Report based on Census 2011 data, “the national disability prevalence is 7.5%” (South Africa 2011: 4). The 2011 report also indicates that disability prevalence is more among females than males (8.3% and 6.5% respectively). This implies that South Africa may have a significant population of WWDs that requires maternal healthcare services.

The number of WWDs requiring maternal services in South Africa is not known because disability conditions of women attending maternal healthcare services are not recorded (Sherry 2014: 9). Furthermore, a few studies explore the experiences of WWDs in accessing maternal services in South Africa (Gichane *et al.* 2017: 436). Some of the challenges include lack of accessible information and communication with healthcare workers on pregnancy childbirth and immediate post-partum even-though there are guidelines or recommendations on how to handle communication needs for WWDs (Gichane *et al.* 2017: 436). In addition, transport to healthcare services has been recorded as another challenge faced by WWDs. There is no provision in the health facilities to accommodate WWDs in terms of access. A study conducted in Durban by Mavuso and Maharaj in 2015 revealed that WWDs felt that public maternal healthcare services were not adequately prepared to cater for the needs of WWDs.

Although the South African government have taken commendable efforts to reduce maternal mortality through key policies, the maternal mortality rate is still significantly high (625 deaths per 100 000 live births) (Sisal *et al.* 2013 and Mayosi *et al.* 2012). While maternal healthcare services are free in South Africa, several women are not accessing these services due to lack of transport and other systemic limitations (Sherry 2014; Gichane *et al.* 2017). In addition, Sisal *et al.* (2013: 130) found out that while the user fee removal policy increased affordability of maternal healthcare services in South Africa, women bear transport costs and purchase supplies required for delivery especially at the clinic. Sisal *et al.* (2013: 130) further contend that the geographical accessibility of the clinic is outweighed

by the costs of buying supplies as well as poor acceptability services. For South Africa to reduce maternal mortality, there is a need to improve access to maternal services especially for the vulnerable populations including WWDs.

2.10 HEALTHCARE CHALLENGES ENCOUNTERED BY WOMEN WITH DISABILITIES DURING PREGNANCY AND DELIVERY

Historically, WWDs have been regarded as asexual and incapable of getting pregnant and delivering and caring for their children (Frohmader and Ortoleva 2012: 8). As a result, there has been a systemic exclusion of WWDs from maternal healthcare services. This is evidenced by that the majority of extant programmes and policies focus on the prevention of pregnancy but trivialise the fact that many people with disabilities will eventually bear children of their own. In the worst-case scenarios, WWDs have to undergo forced sterilisation and coerced abortion and if they go through their pregnancy, poorly managed pregnancy and delivery, as well as termination of parental right (Frohmader and Ortoleva 2012: 9). In addition, maternal healthcare service providers have inadequate knowledge, skills and resources to deal with the intersection of pregnancy and disability and provide disability inclusive maternal services (Ahumuza *et al.* 2014; Hoglund *et al.* 2013 and Lee *et al.* 2015) as the current training does not include how to handle women pregnant WWDs.

A systematic review conducted by Malouf *et al.* (2014: 62) on “healthcare interventions to improve outcomes with disability and their family during pregnancy, birth and post-natal period” only found three articles that met their inclusion articles. Their conclusion was that there is minimal literature on the interventions directed to WWDs. This study revealed that articles reporting interventions mainly report utilised qualitative methodology and were not evaluation studies. The interventions that were described by some of the studies include educational video, family support programme and massage therapy (Malouf *et al.* 2014: 64). Most of the qualitative studies recommend the following interventions for pregnant WWDs; provision of disability pre-service and in-service training that addresses various types of impairments and their implications on the mother's well-being and care, increment of information resources for both maternal healthcare providers and pregnant WWDs, improvement in continuity of care, improvement in integration of the services required by pregnant WWDs, and adoption of a proactive stance by healthcare workers in identifying specific needs of the pregnant WWDs prior to child birth (Lawler *et al.* 2013; Ahumuza *et al.* 2014; Bradbury-Jones *et al.* 2015; Hoglund *et al.* 2013).

Research indicates that WWDs are more likely to experience domestic abuse during pregnancy. In order to understand the impact of abuse on access to healthcare services for women, Bradbury-Jones *et al.* (2015) conducted a study that explored the challenges that were faced by pregnant WWDs who have faced domestic abuse and the strategies to improve access to maternal services for disabled women when they experience domestic abuse (Bradbury-Jones *et al.* 2015: 98). The recommendations of these authors include that there is a need to review training in both disability and domestic abuse so as to facilitate change in culture and stigmatisation of the disabled women who experience domestic abuse. Other researchers also recommend interventions that provide information on the dynamics of intimate-partner violence to be provided to pregnant WWDs (Thiara, Hague and Mullender 2011: 768).

Although there is little research that focuses on healthcare access for WWDs in low- and middle-income countries, existing research indicates that the access to healthcare services is marred by lack of health insurance, high cost of transport and in the rural areas poor drug supply, lack of referral and long waiting times (Sherry 2014; Morrison *et al.* 2014; Ganle *et al.* 2016). Some of the studies from South Africa highlight that people with disabilities have to contend with the lack of adequate communication, poverty and the high cost of transport (Grut *et al.* 2012; Sherry 2014).

Improved access to quality maternal healthcare services (that is, antenatal, obstetrics and post-natal care) is one of the recommended interventions to reduce maternal mortality (Mulaudzi 2017: 1). While measures are being put in place to improve the accessibility of maternal healthcare services, WWDs are still being systemically excluded from such services Sherry (2014: 92). As the Sustainable Development Goals (SDGs) emphasise equitable access to healthcare services, there is a need, especially in low- and middle-income countries, to generate evidence of the lived experiences of WWDs seeking maternal healthcare services. This research would be important for South Africa especially considering that there is only one study that focuses on women with hearing impairments (Gichane *et al.* 2017: 435). WWDs are an essential group that require attention especially in the face of equitable access, reduction of maternal mortality and eradication of mother to child HIV infection.

2.11 SUMMARY OF CHAPTER

The chapter summarises literature available related to access to maternal healthcare services for WWDs. It has shown that access to healthcare services is a challenge for all people with disabilities. The chapter has shown that WWDs

contend with multiple discriminations of being poor, being women and having disabilities. The chapter indicates that there is no single definition of disability. It also highlighted the fact that there is a shift from perceiving disability from the traditional medical perspective to viewing disability from a human rights perspective. The literature reviewed revealed that WWDs face numerous challenges in accessing maternal healthcare services. In addition, there are very few studies examining the experiences of WWDs in accessing maternal healthcare services in sub-Saharan Africa in general and South Africa in particular. As this chapter has indicated that access to maternal healthcare services is a challenge for WWDs, it is imperative for the next chapter to explore in detail what access is and discuss the conceptual framework underpinning the study.

CHAPTER 3: CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

This chapter provides a detailed description of the conceptual framework of assessing access to healthcare services. The framework presented in this chapter is an analytical approach that has been endorsed by the United Nations (UN) and has the potential to inform maternal healthcare services programme actions. It identifies four main components of access, namely availability, affordability, accessibility and quality of healthcare services. Other frameworks of access are also reviewed in this chapter.

3.2 CONCEPTUAL FRAMEWORK FOR THE CURRENT STUDY

A conceptual framework is either a written or visual presentation that “explains either graphically, or in narrative form, the main things to be studied – the key factors, concepts or variables – and the presumed relationship among them” (Miles and Huberman 1994: 18). In the same vein, Osanloo and Grant (2016: 7) state that “the conceptual framework provides understanding of the best way of solving the problem, the specific direction to follow, and the relationship between the variables in the study. The concepts, assumptions and beliefs highlighted by a selected conceptual framework are useful in guiding the research”. In other words, the selected conceptual framework provides the researcher with structured principles which can be used in organising research data. It is important to note that the concepts included in the framework originate from best practices in the research literature included in access to healthcare services. This study was guided by, “the Conceptual Framework of Assessing Access to Healthcare services” (Peters *et al.* 2008: 162). This conceptual framework guided the research methodology, interpretation of results and discussion of findings.

Before describing the conceptual framework, it is important to provide the background of the framework and clear definitions of the concepts included in the framework. As access is central to the framework, the next section describes different ways in which access is conceptualised in relation to maternal healthcare services.

3.3 DEFINITION OF ACCESS TO MATERNAL HEALTHCARE

Access is an important concept in evaluating performance of health systems worldwide (Levesque, Harris and Russel 2013: 181). It is a complex phenomenon which has been defined differently by different authors. The conceptualisation of access can be traced to the 1970s when researchers including, “Bashshur *et al.* (1971); Donabedian (1973); Aday and Anderson (1974); Salkever (1976) and Penchansky (1977) published articles that defined or conceptualised access. Donabedian (1973: 419) and Penchansky (1977: 31) conceptualised access in terms of the degree of fit between the characteristics of the healthcare systems and the characteristics and expectations of the individuals in need of the healthcare systems” (Levesque, Harris and Russel 2013: 183). This definition implies that there is a need to consider that what may be accessible for one individual may not be accessible for the other. For instance, there is a need to consider the needs of people with disabilities as their disability may impact on their access. McIntyre, Thiede and Birch (2009: 181) postulate that what constitutes compatibility for one individual may constitute incomparability for the other.

Some studies conceptualise access as, “a degree of adjustment between the characteristics of the population and those of the healthcare resources” (Levesque, Harris and Russel 2013: 184). For such scholars, access reflects the differential existence of enablers and inhibitors for the beneficiaries of healthcare. To ensure access to healthcare, there is a need to consider the enablers and inhibitors of access for the different beneficiaries of the healthcare services. Therefore, it will be important to conduct research studies that focus on the facilitators and barriers to access to maternal healthcare services for the

different populations including WWDs. For scholars such as Aday and Anderson (1974: 215), access translate to the actual use of healthcare services. For them, access to healthcare services is determined by the following dynamics: predisposing factors, enabling factors, the need for healthcare services and health systems characteristics such as policy, resources and organisation. However, conceptualisation of access as use proved to be difficult in terms of measuring access. McIntyre, Thiede and Birch (2009: 182) noted that interpreting access as use implies that an individual who did not use services or used services differently from the others who have the same need may be considered to have had differential access. The differential access will be dependent on the fact that the other aspects are the same for the individual. However, it would be a challenge to ensure that all the other aspects are the same.

In general, access is perceived as a multidimensional concept which poses challenges to measure. Different scholars emphasise different dimensions. While some scholars emphasise availability of healthcare services, others emphasise affordability and physical accessibility. Below is a table that summarises the definitions and dimensions found in a variety of studies (Bashshur *et al.* 1971; Donabedian 1973; Salkever 1976; Aday and Andersen 1974; Penchansky and Thomas 1981; Dutton 1986; Frenk 1992; Margolis *et al.* 1995; Shengelia *et al.* 2003; Peters *et al.* 2008; Levesque, Harris and Russel 2013: 188).

Table 3.1: Definitions and dimensions of access

Authors	Definitions	Dimensions
Bashshur <i>et al.</i> (1971: 68)	Accessibility as the functional relationship between the population and medical facilities and resources that reflects the differential existence either of obstacles, impediments and difficulties, or of factors that are facilitators for the beneficiaries of healthcare.	
Donabedian (1973: 19)	Accessibility comprising the concept of degree of adjustment between resources and populations.	
Salkever (1976: 472)	Accessibility combining attributes of the resources and attributes of the population.	Financial accessibility Physical accessibility
Aday and Andersen (1974: 213)	Access as entry into the healthcare system.	
Penchansky and Thomas		Affordability Accessibility Accommodation Availability Acceptability
Dutton (1986: 728)	Utilisation viewed as the product of patients' characteristics plus provider and system attributes.	Financial Time Organisational factors
Frenk (1992: 862)	Access as the ability of the population to seek and obtain care. Accessibility is the degree of adjustment between the characteristics of healthcare resources and those of the population within the process of seeking and obtaining care.	
Margolis <i>et al.</i> (1995: 543)	The timely use of personal health services to achieve the best possible outcomes.	Financial Personal Structural
Haddad and Mohindra (2002: 3)	The opportunity to consume health goods and services.	Availability Affordability Acceptability Adequacy
Shengelia <i>et al.</i> (2003: 230)	Coverage: Probability of receiving a necessary health intervention, conditional on healthcare need. Utilisation: Quantity of healthcare services and procedures used.	Physical access Resource availability Cultural acceptability Financial affordability Quality of care
Peters <i>et al.</i> (2008: 162)	Access viewed as including actual use of services. A clear emphasis is given to consider both users and services characteristics in evaluation of access. The notion of fit between users and services is identified.	Quality Geographic accessibility Availability Financial accessibility Acceptability of services

Source: Levesque, Harris and Russel (2013: 188).

3.4 DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

This study was guided by “the conceptual framework for assessing access to healthcare services” (Peters *et al.* 2008: 162) as depicted in Figure 3.1 below. The conceptual framework was also included in the analysis of the different definitions of access by Levesque, Harris and Russel (2013: 188). This framework identifies availability, accessibility, acceptability and quality (AAAQ) of healthcare services as important elements to ensure access to healthcare services. The AAAQ criteria centres around ensuring that equipped maternal health facilities, skilled maternal healthcare providers as well as information about antenatal, delivery and post-natal are available, accessible, acceptable and of good quality. The AAAQ criteria is important in examining the accessibility of maternal healthcare services as it enables the research to accurately pinpoint which dimension of access the women with different impairments are facing challenges when accessing maternal healthcare services. Identifying the challenges and the enablers of access in relation to each dimension guided the researcher on the areas to emphasise in developing a framework that would improve access to maternal services for WWDs.

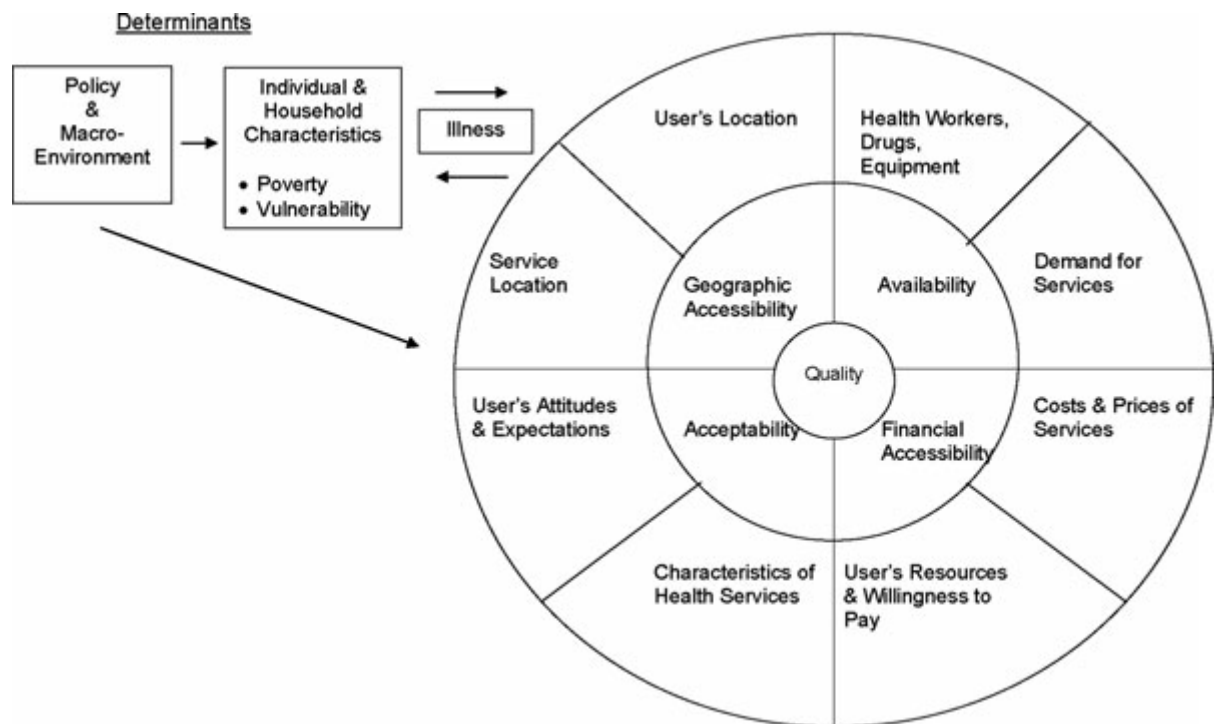


Figure 3.1: Conceptual Framework for Assessing Access to Healthcare Services Source: Peters *et al.* (2008: 162)

3.4.1 Availability

Availability refers to the fact that healthcare facilities, services, goods and healthcare workers are supplied in the right place at the right time to meet the needs of the population (Levesque, Harris and Russel 2013; McIntyre, Thiede and Birch 2009). Availability of healthcare services involves several elements. These elements are summarised by McIntyre, Thiede and Birch (2009: 184) as follows:

- The relationship between the location of healthcare facilities (system factor) and the location of those who need these services and their transportation opportunities (individual factors) (e.g., are obstetric services located and configured in ways that reflect the variations in need of these services in the population?).
- The ability and willingness of service providers to serve the population (system factor) in accordance with the type and severity of their condition

(individual factor) (e.g., are the healthcare workers willing to provide services to pregnant women with different kinds of impairments?).

- The 'degree of fit' between the hours of service of healthcare facilities, or the use of appointment systems (system factors), and the times that individuals need services to be provided (individual factors) (e.g., pregnant WWDs may require more time during consultation, and the question is: are maternal healthcare service providers willing to give them more time?).
- The relationship between the type, range, quantity, and quality of healthcare services provided at a facility (system factors) and the nature and extent of the health needs of the individuals being served (individual factors) (e.g., pregnant WWDs may require other services such as rehabilitation. Do the facilities provide comprehensive services to pregnant WWDs or is there a clear referral pathway between the facility and other services?).”

Access can be restricted if available resources are unevenly distributed around the country or across levels of care, for example, speciality care developed at the expense of primary care (Levesque, Harris and Russel 2013, 183). For maternal healthcare services to be available for WWDs, functional maternal healthcare facilities should be available, and in sufficient quantity. In addition, maternal healthcare services should be provided by skilled maternal health personnel. These skilled healthcare personnel should have adequate knowledge and skills to provide maternal services to pregnant WWDs. Furthermore, the equipment to undertake the perinatal services to WWDs should be available (WHO 2011: 120). Existing research indicates that maternal healthcare providers are inadequately prepared to provide services to pregnant WWDs Walsh-Gallagher Sinclair and Mc Conkey. (2013: 195). In addition, WWDs face challenges on inaccessible infrastructure such as examination and delivery beds and weighing scales (Bremer Cockburn and Ruth. 2010: 212). This study, therefore, explored if maternal healthcare services were available for WWDs through exploring the barriers and facilitators of access to maternal

healthcare services from the perspectives of both the WWDs and the maternal healthcare service providers.

3.4.2 Accessibility

Accessibility covers four dimensions which are physical accessibility (distance to maternal health service), economic accessibility (cost of perinatal care), non-discrimination access and access to information for all sections of the population. Peters *et al.* (2008: 162) emphasise that in developing countries, geographical accessibility and economic accessibility are the most important dimensions of accessibility. However, for this study, all the four dimensions of accessibility will be considered as they ensure access to maternal healthcare services for WWDs.

Physical accessibility implies that “health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS” (WHO 2013: 91). Peters *et al.* (2008: 162) “attest that the physical distance or travel time from service delivery point to the user are important aspects of geographical accessibility of services”. The South African government embarked on programmes to improve geographical accessibility of healthcare services by introducing the PHC services closer to the communities. Even when these healthcare facilities are closer to the communities, research has identified the challenges for pregnant women especially during the night when public transport is not available and, in some instances,, ambulances are too scared to get into the informal settlements.

Financial/ economic accessibility is related to direct costs and indirect costs incurred when seeking for healthcare services. It also includes “eligibility of individuals for financial support and the capacity for people to generate resources for care” (McIntyre Thiede and Birch 2009: 184). Research indicates that WWDs are disproportionately poor and are less likely to be working. In

order to improve financial accessibility of healthcare services to people with disabilities, the South African government has made people with disabilities beneficiaries of financial mechanisms which allow them to access primary healthcare services for free (McKenzie and Hanass-Hancock 2017: 2). In addition, pregnant women and children under the age of five access healthcare services for free (McKenzie and Hanass-Hancock 2017: 2). The effort of making services affordable to vulnerable populations, especially pregnant women, is marred by the costs of buying supplies at the primary level of care (Sikal *et al.* 2013: 130).

Although the conceptual framework of assessing access to healthcare services does not include the non-discrimination access to healthcare services and information accessibility, these are crucial elements of accessibility when considering access to maternal healthcare services for people with disabilities. The non-discrimination element according to UN standards implies that, “health facilities, goods and services must be accessible to all, especially the most vulnerable populations” (WHO 2006: 46). This means that interventions should be tailored to the needs of vulnerable populations such as pregnant WWDs and provision of information in relevant languages, for example, local languages, braille and sign language (McIntyre Thiede and Birch 2009: 184). Since disability constitutes a fundamental ground of inequality, maternal healthcare providers need to always take disability into consideration and all levels. The non-discrimination element is vital for this study. Another element of accessibility that is not considered by the conceptual framework of assessing access to healthcare services is the accessibility of healthcare information. According to the WHO (2006:48), accessibility of information implies that health information and health education should be accessible to all. This implies that information on perinatal care should be made accessible to all including WWDs. Antenatal classes should also include information that relates to WWDs.

3.4.3 Acceptability

Acceptability is defined as, “a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention” (Sekhon, Cartwright and Francis 2017: 95). It considers respect for medical ethics and that the individual’s culture is respected (Sekhon, Cartwright and Francis 2017: 95). Furthermore, acceptability of services implies that maternal healthcare services should be acceptable to pregnant WWDs. The maternal healthcare services providers should respect the fact that WWDs require maternal health services just like other women. Peters *et al.* (2008: 166) contend that there is limited research on how acceptability of health services relate to vulnerable populations.

3.4.4 Quality of services

Perinatal care for WWDs should be scientifically and medically appropriate and of good quality. This requires regular control mechanisms as well as training of maternal healthcare service providers. In addition, care should be provided according to the WHO guidelines. For good quality maternal healthcare services to be provided to WWDs, there is a need for skilled maternal healthcare service providers to be trained in handling pregnant WWDs. Further, scientifically proven and unexpired drugs, and hospital equipment which is suitable for this population should be made available. In the conceptual framework, the quality of services is at the centre of the circle because it relates to all four dimensions. The quality of services also relates to the technical ability of the healthcare services to impact the people’s health (Peters *et al.* 2008: 162).

Over and above the AAAQ criteria, the conceptual framework of assessing access to healthcare services is useful in that “it considers the environmental context impacts, the individual level factors and mediating factors that have an impact on access to maternal healthcare services” (Peter *et al.* 2008: 162). The environmental context includes the following.

- Cultural and social factors.
- Attitudinal factors.
- Physical environment.
- Legal/policy context within which WWDs reside.

The environmental context implies that in order to improve access to maternal healthcare services for WWDs, there is a need to consider both the programmatic and physical access.

3.5 RATIONALE FOR THE SELECTION OF THE CONCEPTUAL FRAMEWORK FOR THIS STUDY

The conceptual framework of assessing access to healthcare services was selected as it builds on to the United Nations Committee on the Economic Social and Cultural Rights' AAAQ criteria (United Nations 2000: 4-5). The AAAQ criteria was used by, "the United Nations High Commissioner for human Rights' technical guidance on a rights-based approach for reducing maternal mortality and morbidity" (United Nations 2000: 3-4). Since the adoption of the AAAQ criteria by the United Nations in 2000, it has been applied to assess different interventions. In addition, the conceptual framework was selected as it was conceptualised considering access to healthcare services in low- and middle-income countries of which South Africa is one.

3.6 APPLICATION OF THE CONCEPTUAL FRAMEWORK

Miles and Huberman (1994: 20) attest that a conceptual framework is useful in guiding research. In this study, the conceptual framework of assessing access to healthcare services was used to guide the research questions. After the data were collected using focus group discussions and in-depth interviews, data analysis was conducted. Data categories and subcategories were identified. During the discussion, the data were described in relation to what the AAAQ criteria says and how the research questions were answered. A new practice framework was developed from the data which represented issues that emerged from the case study in relation to the AAAQ criteria.

3.7 SUMMARY OF THE CHAPTER

This chapter provided details of the complex nature of access to healthcare services. It also summarised the different definitions of access as well as different frameworks of access. Since access to healthcare services is a complex phenomenon, the conceptual framework for assessing access to healthcare services provided a picture of the researcher's perceptions about the phenomenon under study (Osanloo and Grant 2016: 12). In this study, the researcher explored the factors that impact on access to healthcare services. It is important to determine both the demand side and the supply side factors that impact access. The framework provides insights on how the different factors are intertwined to impact access to maternal healthcare services for WWDs. The framework provided a context for interpreting the study findings and developing a practice framework using the issues that emerged from the case study. The next chapter describes the methodology that was utilised in this study.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The overall aim of the study is to develop a practice framework to improve accessibility of maternal healthcare services to women with disabilities (WWDs). For this to be realised, the researcher had to explore the factors that impact access to maternal healthcare services for WWDs in KZN. The qualitative research design employing the case study approach was utilised with the underpinning of an interpretive paradigm. Data were collected from both healthcare workers and WWDs using focus group discussions and in-depth interviews. This chapter summarises the research design and research methods that were utilised in this study. The research methods are described in detail to enable the reader to evaluate the trustworthiness and the quality of the research. The research paradigm and philosophical underpinnings of the research design are also described. The chapter ends with a discussion on how trustworthiness was ensured and a discussion on the ethical considerations.

4.2 RESEARCH DESIGN

After a researcher has identified the research problem, they must identify an approach which would be utilised in investigating the problem. This approach is known as a research design. Yin (2014: 28) defines a research design as “a logical plan for getting here from there, where here may be defined as the initial set of questions to be asked and there and the set of conclusions (answers) about the questions”. Saunders, Lewis and Thornhill (2009: 137) also attest that research design refers to “the overall strategy that the researcher chooses to integrate the different components of the study in a coherent and logical way, thereby ensuring that the researcher will effectively address the problem”. The research design, “articulates what data are required, what methods are going to be utilised to collect and analyse data and how this is going to answer the questions” (Asenahabi 2019: 77). The choice of the research design is dependent on the purpose of research.

While, the purpose of the research is classified into three categories, namely exploratory, descriptive and explanatory, this study adopts the explorative study design. The explorative research design is suitable for the study as this research seeks to provide answers to the question 'What are the barriers and facilitators of access to maternal healthcare services for women with disabilities in KZN?' The explorative study design was suitable for the study as the research problem (access to maternal healthcare services for WWDs) is an under researched area especially in low- and middle-income countries and KZN in particular. It enabled the researcher to find out what is happening; to seek new insights; to ask questions and to assess access to maternal healthcare services for WWDs (Robson 2002: 59). The purpose of research helps to determine the research design, data collection methods and selection of participants. The section below describes the research design that was utilised in this study.

According to Austin and Sutton (2014: 436), qualitative research involves asking participants about their experiences of things that happen in their lives. It enables researchers to obtain insights into what it feels like to be another person and to understand the world as other experiences it. Ritchie and Lewis (2003: 5) also define qualitative research as "methods that are used to address research questions that require explanation or understanding of social phenomena and their contexts. They are particularly well suited to exploring issues that hold some complexity and to studying processes that occur over time". This study utilised a qualitative case study design to explore the factors that impact access to healthcare services for WWDs. The qualitative case study research design enabled the researcher to generate in-depth information that was utilised to develop a framework to improve access to maternal healthcare services for WWDs.

According to Ely *et al.* (1991: 4), some of the characteristics of qualitative research are as follows:

- "Events can be understood adequately only if they are seen in context. Therefore, a qualitative researcher immerses her/himself in the setting.

- The contexts of inquiry are not contrived; they are natural. Nothing is predefined or taken for granted.
- Qualitative researchers want those who are studied to speak for themselves, to provide their perspectives in words and other actions. Therefore, qualitative research is an interactive process in which the persons studied teach the researcher about their lives.
- Qualitative researchers attend to the experience as a whole, not as separate variables. The aim of qualitative research is to understand experience as unified”.

The above-mentioned characteristics defined this study. The research was conducted in a natural setting. The barriers and facilitators of access to maternal healthcare services were explored through the perceptions of maternal healthcare workers and WWDs. As this study sought to understand the factors that impact on access on maternal healthcare for WWDs, the qualitative research design enabled the research to explore these factors from the perspectives of both the WWDs and the healthcare providers. Qualitative research covers a broad range of approaches. These approaches include ethnography, narrative, phenomenological, grounded theory, and case study (Creswell 2014: 104). This research adopted the case study design which allowed the exploration of complex phenomena in detail.

4.3 CASE STUDY

According to Yin (2014: 16), “a case study design is an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not evident; and in which multiple sources of evidence are used”. In this study, accessibility of maternal healthcare services for women is the phenomena and the context is maternal healthcare service facilities located in eThekweni District in KZN. The researcher cannot explore access to maternal services without exploring the maternal healthcare facilities.

In addition, “a case study is a form of empirical inquiry that enables the in-depth examination of a particular phenomenon, issue or object in real life situations. With respect to this study, there were no experimental groups” (Yin 2014: 10). Furthermore, research indicates that case studies are useful in less well-developed research particularly where examination of context and the dynamics of the situation are important (Yin 2014: 10). In the case of this study, access to maternal healthcare services is a complex phenomenon which is impacted upon by numerous factors. The context of the study was maternal healthcare services. The issue under discussion which is access to maternal healthcare service and the context which is maternal healthcare services could not be separated. As a result, the case study was the most suitable design as it allowed the context and the phenomenon to be explored in depth to inform the conceptual framework to improve accessibility of maternal healthcare services.

Case studies have been classified into three categories, which are exploratory, descriptive and explanatory (Yin 2014: 9). As this study focused on an area which is not well-researched, the explorative case study was utilised. In addition, the main question of this research study is, “what are the factors that influence access to maternal services for women with disabilities in the Province of KZN?” An explorative case study design was deemed suitable as case studies that answer the question what and how are considered as exploratory in nature (Yin 2014: 9). There are different types of case studies. These include single case study and multiple case study. The single case study is whereby one case is being examined and a multiple case study describes a study examining several cases. “In multiple case studies, each case is studied as if it is singular and then is compared to other cases” (Baxter and Jack 2008: 550).

This study utilised the single case study design where accessibility of maternal services for WWDs in the province of KZN was examined. Furthermore, a case study can be either a holistic or embedded. An embedded case study occurs when attention is given to a subunit or subunits (Yin 2014: 53). In this case

study, the different levels of maternal healthcare services were considered. These levels included Community Healthcare Centre (CHC), district hospital, regional/provincial hospital, tertiary hospital and a national hospital (Facility A, Facility B, Facility C, Facility D and Facility E). The embedded case study allowed the researcher to understand the factors influencing access to maternal services for WWDs from all levels of maternal healthcare services. Furthermore, the researcher was able to understand the differences and similarities in terms of the factors influencing access to maternal services for WWDs between these levels of maternal healthcare services. Since the ultimate aim of this study was to develop a practice framework for improving accessibility of maternal healthcare services for WWDs, an embedded case study was selected as it allowed for a wider exploration of the research questions and theoretical evolution (Baxter and Jack 2008: 550).

The case study was undertaken in two phases. The first phase was to investigate the factors that influence access to maternal services for WWDs in the province of KZN. The second phase was the development of a practice framework for improving access to maternal healthcare services for WWDs. The strength of a case study approach was that information was gathered from different sources which included WWDs and maternal healthcare workers. In addition, the information was gathered using different methods of data collection. These methods included in-depth one-on-one interviews with WWDs and focus group discussions with maternal healthcare workers.

4.4 THE BACKGROUND OF THE STUDY

The origins of the case study methodology are attributed to studies undertaken in anthropology and social sciences in the early 20th century (Harrison *et al.* 2017: 2). During this period, detailed ethnographic studies of individuals and cultures were conducted using the case study research method. These early case studies were undertaken in the natural setting of the participants. As positivist deductive approaches to research became popular in the late 1940s and early 1950s, case studies were used as a method with quantitative

research or as descriptive research to study specific phenomena (Harrison *et al.* 2017: 2). However, during this period the case study as research design was criticised for utilising small sample sizes unlike other quantitative designs. The small sample sizes meant that the case study design could not be generalised and had limited validity.

From the 1920s and 1950s, the medicine and disciplines of social sciences such as sociology, education and political science took case study as a form of a research inquiry. The use of case study design became more popular after the introduction of the grounded theory as a qualitative approach. “Yin presented a structured process for undertaking case study research where formal propositions or theories guide the research process and are tested as part of the outcome, highlighting his realist approach to qualitative case study research” (Harrison *et al.* 2017: 4). However, in the context of healthcare research, case studies are a bridge between two paradigms thereby resulting in some case studies being either qualitative or quantitatively oriented while others incorporate both qualitative and quantitative aims and methods.

4.5 PHILOSOPHICAL VIEWS UNDERPINNING THE STUDY

The approach or research design is dependent upon how the researcher perceives the problem and how the researcher thinks about how the problem can be studied with the goal of producing credible findings. Every researcher has his or her views of what knowledge is. The researcher's opinions, experiences, perceptions and attitudes will guide the approach of investigating the problem (Creswell 2014: 4). Guba (1990: 17) defines the philosophical views as a basic set of beliefs that guides action. While some authors refer to philosophical views as research paradigms, other authors contend that research paradigms comprise the philosophical views as well as the research methods (Scotland 2012; Creswell 2014). Guba and Lincoln (1982:233) note that there are many paradigms of research inquiry.

The three main paradigms of research inquiry include positivism, constructivist/interpretivist and pragmatism. While, positivism is more inclined to quantitative research methods, constructivist/ interpretivist is more inclined to qualitative research methods and the pragmatism more inclined to mixed methods. Embedded within each paradigm are four sub-components of research enquiry namely, a) ontology, b) epistemology, c) axiology and d) methodology (Scotland 2012:9). To understand why each research paradigm is aligned to a particular research method, it is vital to explain what each subcomponent of the research paradigm entails. While ontology explains what reality is, epistemology describes how knowledge is created and communicated, axiology defines the ethical requirements and researchers' stand view in a study and methodology which outlines the plan of action (Guba and Lincoln 1982 and Austin and Sutton 2014).

The epistemological and ontological positions of a researcher result in differing research approaches in investigating the same phenomenon (Grix 2004: 64). The ontological perspective of research is concerned with nature of reality which is because of the assumptions that the researcher has on the how the world operates. There are two aspects of ontology which include subjectivism and objectivism. "While objectivism portrays the view that social entities exist in reality external to social actors concerned with their existence, subjectivism portrays those social phenomena are created from the perceptions and consequent actions of those social actors concerned with their existence" (Saunders, Lewis and Thornhill 2009: 110). Through objectivism, knowledge is perceived as hard and tangible whereas through subjectivism knowledge is perceived as personal and unique. The ontological perspective of this research, therefore, is that there is no single reality but individuals in groups create reality (Groenewald 2004: 44). In this study, the participants include WWDs and the maternal healthcare providers. The interaction between the healthcare workers and the WWDs impact on access to maternal healthcare services for WWDs.

Epistemology concerns “what constitutes acceptable knowledge in the field of study” (Saunders, Lewis and Thornhill 2009: 112). Central to the epistemology is how one gets to know reality. The epistemological position of this study was formulated as follows; data are contained in the WWDs seeking maternal healthcare services, maternal healthcare service providers and research conducted by others. To ensure subjectivity of the study findings, the researcher further discussed trustworthiness or validity and reliability of the study to eliminate bias.

The research approach included the philosophical views, definition of assumptions, formulating of research questions and collection of data, data analysis and interpretation. The research assumptions were as follows:

- The lived experiences, perceptions and attitudes of access to maternal health services by WWDs and maternal healthcare providers will determine the accessibility of maternal healthcare services by WWDs.
- The understanding and interpretation of multiple meanings that the groups attributed to the factors that impact access to maternal healthcare services could provide a description of the practice required to improve accessibility of maternal healthcare services for WWDs.
- The different levels of maternal healthcare services may have different factors impacting access to maternal healthcare services for WWDs.

Basing on the above-mentioned factors, this study utilised the constructivist/interpretive philosophy. The interpretive paradigm allowed the researcher to explore the accessibility of maternal healthcare services through the perspectives of the WWDs. “Interpretive methodology is directed at understanding phenomenon from an individual’s perspective, investigating interaction among individuals as well as the historical and cultural contexts which people inhabit” (Creswell 2014: 8). In this study, WWDs perspectives as well as maternal healthcare workers’ perspectives regarding access to maternal healthcare services were explored. The context of the study was the maternal healthcare facility.

4.6 NATURAL SETTING

Qualitative research involves studying participants in their natural setting. Because qualitative research involves small sample sizes, the results are not generalisable. In order to enhance the generalisability of findings to the areas that have similar context as the one in which the research was undertaken, it is important to describe the natural setting in detail.

This research was conducted in KZN, which is one of the nine provinces in South Africa located in the southeast of the country (Mashamba Thompson *et al.* 2016: 2). The province of KZN has the second largest population after Gauteng province (South Africa 2017: 1). According to the 2017 mid-year population estimates, there were 56.52 million people in South Africa and approximately 11.1 million (19.6%) live in the province of KZN (Statistics South Africa (Stats SA) 2017). The province of KZN is made up of four population groups: “87% African, 7.4% Indian, 4.2% White, and 1.4% Coloured” (South Africa 2014: 28). The Statistics South Africa Report based on Census 2011 data, also indicates that the KZN Provincial disability prevalence is 8.4%. The healthcare system in South Africa comprises the public and private health sectors. The public health sector consists of primary health, district hospitals, regional hospitals, tertiary hospitals and national hospitals (Scheffler *et al.* 2017: 5). EThekweni district was selected as it has all the levels of healthcare facilities from primary health to the national healthcare facilities. Maternal healthcare workers were drawn from the following facilities, Facility A, Facility B, Facility C, Facility D and Facility E. These healthcare facilities were selected to represent the different levels of care, that is, primary, district, regional, tertiary and central to allow understanding of the factors that influence access to maternal healthcare services at each level of care.

To ensure that WWDs share their experiences in a comfortable environment, they were interviewed in their homes or in the organisations. In all the instances, the environment chosen would ensure confidentiality. The focus group discussions with maternal healthcare service providers were held in their

workplace. A boardroom was sought from the facilities that these maternal healthcare service providers work, and the focus group discussions were held in that boardroom.

The public health sector was selected as it is “the main provider of healthcare services in South Africa and used by the full range of socio-economic groups; even the highest income quintile uses public sector services, albeit largely at the central hospital level” (McIntyre and Ataguba 2011: 65).

4.7 SAMPLING PROCESS

Sampling can be defined as the process through which research participants or data sources from which data to address the objectives will be obtained are selected (Gentles *et al.* 2015: 1775). While there are two broad categories of probabilistic and non-probabilistic, this study utilised the non-probabilistic sampling. Gentles *et al.* (2015: 1776) further explain that sampling applies at two levels, that is, the case and the unspecified data sources within the case. In this study, sampling was applied at the maternal health service facility level and the data sources which include maternal healthcare workers and WWDs. The next section describes the sampling process of the healthcare facilities, maternal healthcare workers and WWDs.

4.7.1 Population

The target population for this study was WWDs who are currently pregnant or had been pregnant in the previous five years. Maternal healthcare services included antenatal, childbirth and immediate postnatal. The WWDs included those who were pregnant and seeking or would have sought maternal healthcare services either at a local clinic, district hospital, regional hospital or provincial hospital or at the national hospital.

4.7.2 Health facilities

Criterion purposive sampling strategy was utilised to select the healthcare facilities. The main reason for using purposive criterion sampling was to ensure that the healthcare facilities are chosen to fulfil the key criterion (Ritchie and Lewis 2003: 49). In the KZN province, the eThekweni district was selected as it is the district that has facilities with all the levels of maternal healthcare services. The heterogeneous or multivariable sampling was chosen. This sampling method allowed for inclusion of phenomena which widely vary from each other with the aim of identifying central themes which cut across the variety of cases (Ritchie and Lewis 2003: 49). In this study, the heterogeneous cases include Community Healthcare Centre (CHC), district hospital, regional hospital, tertiary and central hospital. These facilities included Facilities A, B, C, D and E.

4.7.3 Healthcare providers

The population for health workers comprised providers of maternal healthcare services which included midwives and gynaecologists from Facilities A, B, C, D and E. The researcher sought permission from the Chief Executive Officers (CEOs) of these facilities to contact Human Resource Departments in order to identify the potential participants namely, the midwives and gynaecologists as well as provide their contact details such as telephone numbers. The researcher then contacted the person in charge of the midwives and gynaecologists to set up a meeting to meet with potential participants. Criterion sampling was used to select midwives and gynaecologists from each healthcare facility. A total sample size of at least five midwives and five gynaecologists was selected where each healthcare worker was from each of the five healthcare facilities. In this way, the category of healthcare workers selected would account for each of the five different healthcare facilities that provide maternal healthcare services. The researcher then contacted the maternal healthcare workers she had identified.

4.7.4 Types of healthcare workers

The paragraphs below describe healthcare workers included in the study. In this study, gynaecologists and midwives are considered as the healthcare workers.

4.7.4.1 Gynaecologists/ Obstetricians

A gynaecologist or obstetrician is a physician specialist who provides medical and surgical care to women and has expertise in pregnancy, childbirth, and disorders of the reproductive system. This includes preventative care, prenatal care, and detection of sexually transmitted diseases, Pap test screening and family planning. For this study, a gynaecologist or an obstetrician refers to a physician specialist providing his/her expertise in pregnancy and childbirth services. These medical specialists have worked in public maternal healthcare services for at least one year.

4.7.4.2 Midwives

Midwife refers to “a person who has been admitted to a midwifery educational programme, duly recognised in the country in which it is located, who has successfully completed the prescribed course of studies in midwifery, and who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery” (Fullerton *et al.* 2003: 1). Midwives help women during labour, delivery, and after the birth of their babies. They may deliver babies at birthing centres or at home, but most can also deliver babies at a hospital. In this study, midwives referred to professionals helping women during labour, delivery and after birth.

4.8 SAMPLING APPROACH

Sampling can be defined as “the process through which research participants or data sources from which data to address the objectives will be obtained are selected” (Gentles *et al.* 2015: 1775). While there are two broad categories of probabilistic and non-probabilistic, this study utilises the non-probabilistic

sampling. Gentles *et al.* (2015: 1776) further explain that sampling applies at two levels, that is, the case and the unspecified data sources within the case. In this case study, sampling applied to the case which is maternal healthcare services and the data sources which included WWDs and maternal healthcare workers.

4.8.1 Sampling approach for maternal healthcare services

The province of KZN has eleven health districts, namely, Amajuba, eThekwini, iLembe, Harry Gwala, King Cetshwayo, uGu, uMgugundlovu, uMkanyakudhe, uMzinyathi, uThukela and Zululand. Out of these 11 districts, only eThekwini has all the level of maternal healthcare services. The researcher utilised the criterion sampling to select eThekwini district as it was the only district that would allow the researcher to explore the different levels of maternal healthcare services.

EThekwini is further divided into eight sub-districts which include South Central, South-West, Umlazi Engonyameni, Lower South, North Central, Greater Inanda/Tongaat, Inner-West and Outer West. Criterion Sampling was used to select the South-Central sub-district as it is the district that comprises maternal healthcare services at all the four levels of care. The sub-district includes Cator Manor Community Healthcare Centre, Wentworth District Hospital, Addington Regional Hospital, King Edward Tertiary Hospital and Inkosi Albert Luthuli National Hospital.

According to the World Medical Association (WMA) (2013: E3), research protocols that involve human subjects should be submitted for consideration comments, guidance and approval to the concerned research ethics committee prior to the collection of data. After provisional ethical clearance was provided by DUT IREC, (Appendix 1), the researcher requested and obtained the gatekeeper permission from the eThekwini District Health Manager (Appendices 2a and 2b) and KZN Department of Health (Appendices 3a and

3b). Thereafter, the researcher requested and obtained gatekeeper permission from the selected health facilities CEOs (Appendices 4a and 4b).

4.8.2 Sampling for women with disabilities

With regards to WWDs, the researcher requested the KZN Department of Social Development and the CEO of each health facility to provide a list and address of WWDs residing in eThekweni district. These women were at second trimester of their pregnancy or were pregnant in the past five years. As this is a qualitative study, the non-probability sampling was used where the researcher purposively selected information rich cases from which to collect data for the study (Patton 1990: 169). In the current study, the criterion sampling was utilised to select women with visual, hearing, and physical impairments and who were at second semester of pregnancy or were pregnant in the past five years (Patton 1990; Harsh 2011).

A minimum of 12 WWDs were selected. Of these 12, four were women who were visually impaired, four with hearing impairments and four who were physically impaired. However, data collection continued until a point when no new information could be obtained from the WWDs. This sampling strategy enabled the researcher to account for the impact of the different impairments on access to maternal health services. In addition, this sampling strategy enabled the researcher to include WWDs who are currently pregnant and those who have been pregnant in the past five years. The researcher visited these women at their homes to request them to participate in the study. Necessary provisions for communicating with women with different impairments were put in place. For instance, in cases of women with hearing impairments, the researcher engaged a sign language interpreter.

4.8.3 Sampling of healthcare providers

The population for health workers comprised providers of maternal healthcare services which included midwives and gynaecologists from Facilities A, B, C, D and E. The researcher sought permission from the CEOs of these facilities to

contact Human Resource Departments in order to identify the potential participants namely, the midwives and gynaecologists as well as provide their contact details such as telephone numbers. The researcher then contacted the person in charge of the midwives and gynaecologists to set up a meeting to meet with potential participants. Criterion sampling was used to select midwives and gynaecologists from each healthcare facility. A total sample size of at least five midwives and five gynaecologists was selected where each healthcare worker was from each of the five healthcare facilities. In this way, the category of healthcare workers selected accounted for each of the five different healthcare facilities that provide maternal healthcare services. The researcher contacted the maternal healthcare workers she would have identified.

4.9 INCLUSION AND EXCLUSION CRITERIA

Inclusion and exclusion criteria define who can be included and who is excluded in the study. “While the inclusion criteria identify the study population in a consistent, reliable, uniform, and objective manner, the exclusion criteria include factors or characteristics that make the recruited population ineligible for the study” (Garg 2016: 647).

4.9.1 Women with disabilities

Inclusion criteria

- Women with disabilities (that is women with a physical or mobility impairment, sensory impairment such as impaired vision and impaired hearing) who sought public maternal healthcare services (antenatal, perinatal and immediate postpartum).
- Women with disabilities who were pregnant in their first and second trimester.
- Women with disabilities who had a child in the past five years.
- Women with disabilities residing in KZN.
- The age group between 18 and 45 as this is the reproductive age group.

Exclusion criteria

- Women with cognitive impairments as they would not be able to give consent to participate in the study.
- Women with disabilities who had never been pregnant.
- Women with disabilities who were pregnant but are in their third trimester.
- Women with disabilities who had never had a child more than five years.
- Women with disabilities who were below 18 years and those who are 45 years and above.

4.9.2 Healthcare facilities

Inclusion criteria

- The healthcare facilities located in KZN.
- The healthcare facilities located in eThekweni district.
- The healthcare facilities providing maternal healthcare services.
- These facilities were public healthcare facilities.

Exclusion criteria

- Private healthcare facilities.
- Healthcare facilities in other provinces other than KZN.
- Healthcare facilities in other districts other than eThekweni.

4.9.3 Healthcare workers

Gynaecologists/ Obstetrician

Inclusion criteria

- The gynaecologist or obstetrician were working at the public maternal healthcare facilities in eThekweni district in Sub-district 1.
- The gynaecologist or obstetrician had worked at least one year working experience at the present facility and providing maternal healthcare services.

Exclusion criteria

Gynaecologists/ Obstetrician from private hospitals

Exclusion criteria

- Gynaecologists or obstetricians from private hospitals.
- Gynaecologists or obstetricians who are in public maternal healthcare facilities in other sub-districts other than eThekweni sub-district 1.
- Gynaecologists or obstetricians who had less than one-year experience in providing maternal healthcare services at the present facility.

Midwives

Inclusion criteria

- The midwives working at the public maternal healthcare facilities in eThekweni district in sub-district 1.
- The midwives had at least one year of working experience at the present facility and providing maternal healthcare services.

Exclusion criteria

Midwives from private hospitals

- Midwives from private hospitals.
- Midwives' public maternal healthcare facilities in other sub-districts other than eThekweni sub-district 1.
- Midwives who had less than one-year experience in providing maternal healthcare services at the present facility.

4.10 DATA COLLECTION PROCESS

4.10.1 In-depth interviews

An interview is defined as “extendable conversation between partners that aims at having in-depth information about a certain topic or subject and through which the phenomena could be interpreted” (Ritchie and Lewis 2014: 36). In-depth interviews were used to gather information on the experiences of WWDs in accessing maternal healthcare services. They provided in-depth

understanding of the phenomena under study as they offered an opportunity for clarification of ambiguous responses; they explored more deeply individuals' perceptions on issues under discussion (Ritchie and Lewis 2003: 36).

Since the researcher is not fluent in isiZulu, interviews were conducted by the researcher with the help of a research assistant who was a Masters student who understands research methodology and is fluent in both English and isiZulu. The interview guide contained questions addressing the main research questions (Appendices 8a and 8b). However, the interview guide was not used as a rigid structure. Where necessary, the interviewer asked follow-up questions for clarification even if they are not included in the interview guide. If issues that are not addressed in the interview guide kept coming up repeatedly during the interviews, the interview was amended to include questions around these issues. The interviews were undertaken until data saturation was reached. Data saturation is whereby no new information is obtained from the interviews (Austin and Sutton 2014: 438). Interviews were conducted in the homes of the WWDs.

Permission was sought from the participants to voice record the interview discussions. Each interview session took between approximately 45 minutes and one hour to allow for a detailed discussion of the issues. The researcher took some notes during each interview to act as back up in case the taping did not work. After each interview, the researcher compiled some notes on accessibility issues that were raised and how they can be incorporated in a practice framework that I would develop. After interviewing all the WWDs, the interviews were transcribed verbatim. However, the names of the participants were not included in the transcriptions to ensure confidentiality. Interviews that were undertaken in isiZulu were transcribed into the language used during the interview. These transcriptions were then given to a professional translator to translate them into English.

4.10.2 Focus group discussions

According to Barbour and Schostok (2005: 46), “a focus group discussion is an interview technique which is conducted with participants that are selected because they are part of a specific population and the group being focused on a given topic”. The focus group discussions were held with the maternal healthcare providers from Facilities A, B, C, D and E. To ensure diversity of information, each focus group discussion included different types of maternal service providers (midwives, obstetricians and gynaecologists) from different levels of care (provincial, regional, district and clinic). The focus group discussions were held in one of the hospital’s boardrooms. Permission was sought from the participants to voice record the discussions. The focus group took approximately an hour to allow for a detailed discussion of the issues.

4.11 DATA ANALYSIS

A framework analysis was utilised to analyse qualitative data. “The frame work analysis involves five steps which are familiarisation, identifying a thematic framework, indexing, charting and mapping interpretation” (Srivastava and Thomson 2009: 4).

Familiarisation: Familiarisation is the process by which the researcher becomes familiar with the data collected be it interviews or focus group discussion. The researcher used the process of transcription to start familiarisation with the data. The researcher continued listening to the audio recordings as well as studying the research notes to get a deeper understanding of the collected data. The process also aided the interpretation of the data.

Identifying thematic framework: The transcription of data and the familiarisation process helped the researcher to start identifying the emerging themes and issues from the data. The researcher immersed herself into the data and identified the themes that emerged from the data.

Indexing: During this process, the researcher identified portions of the data that correspond with certain themes.

Charting: Data were arranged into frame by putting the text that relates with the same theme together.

Mapping and Interpretation: The researcher then analysed the key characteristics as laid out in the charts or matrices.

The framework analysis was appropriate for this research as it facilitated the development of matrices, which allowed the researcher to categorise the factors that influence access to maternal healthcare services according to the nature of disability as well as different levels of care. In addition, all the concepts and issues identified were from the perspectives of the participants.

4.12 TRUSTWORTHINESS FOR QUALITATIVE STUDY

According to Guba (1981: 84), trustworthiness is a framework, which includes credibility, transferability, confirmability and dependability, which are aspects that are used to evaluate qualitative research. Four different components of the trustworthiness framework are described below.

4.12.1 Credibility

Credibility refers to how researchers ensure rigor in the research process (Guba 1981: 84). In this study, rigor was enhanced by triangulation of data sources (Heale and Forbes 2013: 98). These data sources included maternal services and WWDs. In the analysis stage, the feedback from these data sources was compared to find areas of agreement as well as disagreement. The researcher worked with other researchers who have conducted research on WWDs. These seasoned researchers provided guidance on how the research would be conducted. In addition, the interview question guide and the focus group guide were piloted to facilitate improvements of the instruments.

4.12.2 Confirmability

Confirmability refers to “measures put in place by the researcher to ensure that the findings are because of the experiences and ideas of the informants rather than the characteristics and preferences of the researcher” (Shenton 2004: 72). To enhance confirmability, the researcher used frequent debriefing sessions with the supervisors to give the researcher an opportunity to discuss alternative approaches (Guba 1981: 86). Confirmability was enhanced by triangulating the data sources that are; WWDs and maternal healthcare service providers.

4.12.3 Transferability

According to Anney (2014: 277), transferability refers to “the degree to which the results of a qualitative research can be transferred to other contexts with other respondents”. To ensure transferability, the researcher provided a detailed description of the research context and the phenomenon under study. As this is a qualitative study that utilised small sample sizes, the description of the context helped in having the results to be generalised to other places that have similar contexts. In addition, the researcher provided the details of the inclusion and exclusion criteria of the people who provided the data. Furthermore, the researcher provided the details of maternal healthcare facilities where the research was conducted.

4.12.4 Dependability

Anney (2014: 278) states that “dependability refers to the consistency with which the study could be replicated producing the same results”. Dependability in qualitative research is achieved by triangulation of methods of data collection methods. In this study, two different data collection methods were utilised: focus group discussions and in-depth interviews. In addition, the field notes, raw data, interview notes and focus group notes were kept for cross-checking the inquiry process.

4.13 ETHICAL CONSIDERATIONS

According to Fouka and Matzou (2011: 4), the major ethical considerations in conducting research include informed consent, beneficence, justice, respect of anonymity and confidentiality, and respect of privacy. Below is the description of how ethical considerations were followed.

4.13.1 Informed consent

Informed consent implies that no research involving human beings should be undertaken without getting permission from the participants' legally authorised representatives (Touitou *et al.* 2004 and Mandal and Parija 2014). To ensure informed consent, the ethical approval for conducting this study was obtained from the Institutional Research Ethics Committee at the Durban University of Technology (DUT) (IREC 078/18) (Appendix 1). Gatekeeper permission to conduct the study was sought from the eThekweni District Manager (Appendices 2a and 2b), KZN Department of Health (Appendices 3a and 3b), (as well as from the CEOs of the selected health facilities (Appendices 4a and 4b). In addition, a letter was submitted to the Department of Social Development (Appendices 5a and 5b) to request for the database of WWDs who reside in eThekweni District who have been pregnant or are currently pregnant.

Informed consent also refers to “respect for the individual’s right to make decisions about themselves and their life (respect for autonomy). It requires that research participants are adequately and properly informed regarding the nature of the research project” (Mandal and Parija 2014: 79). For instance, the prospective participants must be informed about what will be required of them, including the estimated time requirement. To ensure informed consent, a letter of information was made available to the potential participants, which provided the details of the study (Appendices 6a and 7a). A translated letter of information was provided to participants who were not familiar with English (Appendix 6b).

Thereafter, a written informed consent was sought from them (Appendix 8a). A translated consent form was provided to participants who are not familiar with English (Appendix 8b). Participants were informed that participation in the study was voluntary and that they could withdraw at any stage of the research without any form of penalty. The researcher encouraged the participants to ask any remaining questions relating to the study before starting the interview and focus group discussion.

The results of this study were made available to the participating WWDs, Department of Social Development, Department of Health and the organisations that work with WWDs. The data collected were stored securely and will only be accessed by the principal researcher. The data will be disposed after five years.

4.13.2 Confidentiality

Confidentiality implies that “researchers must collect data without compromising the identities of the respondents” (Touitou *et al.* 2004: 163). In this study, codes were used to protect the participants’ confidentiality. The researcher disclosed information in a manner not traceable to any of the respondents. The personal information obtained through the research was only used for the study and all data were entered anonymously to maintain participants’ confidentiality. In addition, the confidentiality of the facilities was also protected by using the letters of the alphabet to refer to each facility.

4.13.3 Beneficence and non-maleficence

Any research should benefit the participants and not harm them in any way. According to Anderson *et al.* (2010: S3), beneficence refers to the balance between the benefits of research against the risks and costs. To ensure beneficence, the research should benefit the participants. Anderson *et al.* (2010: S3) also define non-maleficence as, “avoiding the causation of harm”. This implies that if the research causes some harm, the harm should be outweighed by the benefits. To ensure beneficence, the results of this study were made

available to the participating WWDs, Department of Social Development, Department of Health and the organisations that work with WWDs. To avoid harm, the data collected were stored securely and will only be accessed by the principal researcher. The data will be disposed after five years.

4.14 SUMMARY OF THE CHAPTER

This chapter described the methods that were utilised in conducting the study. The researcher utilised the qualitative research design using the case study approach. This chapter highlighted the philosophical underpinning of the research paradigm, design and methods. Furthermore, it discussed the analytical procedures of the study by describing the sampling method, data collection and analysis. The researcher provided a detailed description of the methodological decision to facilitate the evaluation of the quality of the study. The chapter also discussed the strategies of enhancing trustworthiness. This chapter ends with a description of how ethical considerations were followed. The next chapter presents the findings of the research.

CHAPTER 5: PRESENTATION OF FINDINGS

5.1 INTRODUCTION

The study aimed to explore the factors that impact access to public maternal healthcare services for women with disabilities (WWDs) in KZN. The goal was to develop a practice framework to improve access of WWDs to maternal healthcare services. The four questions addressed in this study were:

- What are the practices of maternal healthcare service providers in providing service to women with disabilities?
- What are the perceptions of maternal healthcare service providers with regard to access to maternal healthcare services for women with disabilities?
- What are the perceptions of women with disabilities with regard to access to maternal healthcare services?
- What would improve access to maternal healthcare services for women with disabilities?

In order to develop a practice framework, it is important to understand how WWDs are currently accessing maternal healthcare services. In this study, the understanding of how WWDs are currently accessing maternal healthcare services was enhanced by conducting focus group discussions with maternal healthcare service providers and in-depth interviews with the WWDs who have accessed maternal healthcare services. The collected data were analysed for their relevance to the research questions.

This chapter presents findings from focus group discussions of midwives in five healthcare facilities. While the researcher intended to conduct focus group discussions with gynaecologists, the researcher ended up conducting one-on-one telephonic interviews with the gynaecologists using the focus group interview guide. This was due to the challenge of getting all the gynaecologists free at the same time. As a result, the researcher had to interview each

gynaecologist separately during his or her free and convenient time. The chapter further presents results from interviews of WWDs who fulfilled the research criteria in the eThekweni District. In so doing, it first summarises the demographic information of the midwives, gynaecologists and WWDs who participated in the study and then presents the findings of the study as themes. The chapter concludes with a summary.

5.2 DESCRIPTION OF PROFILE OF THE STUDY PARTICIPANTS

The participants comprised 16 midwives, four gynaecologists and one medical officer and 12 WWDs who fulfilled the research criteria. The gynaecologists and midwives worked in the five facilities that were selected for the study. Based on the information collected from the participants, the researcher describes the demographics of the midwives, gynecologists and WWDs, respectively. Data saturation was reached by the time the researcher interviewed the 15th midwife and the third gynecologist. Furthermore, data saturation for WWDs was reached when the researcher interviewed the third woman for each specific impairment.

5.2.1 Demographic profile of midwives

The researcher employed criterion sampling to 16 participants from 558 midwives who provide maternal services at various facilities within eThekweni District. All the participants willingly participated in the study. The demographic profile of each participant is depicted in Table 5.1 below. All the midwives were female. Their ages ranged from 20-60 years. Of the 16 midwives, 10 were aged between 20 and 40 years and 6 were aged between 41 and 60 years. Amongst these midwives, 10 were Africans, three were Indians and three were coloureds. Their work experience ranged from 1 year to 32 years. Nine had experience of between one to ten years, 4 of them had experience of 11 to 20 years and 3 of them had experience of 21 to 30 years.

Table 5.1: Demographic profile of midwives

Participant No.	Gender		Age (years)			Race	Work experience years		
	M	F	20-40	41-60	61-80		1-10	11-20	21-30
M.1		X	X			African		X	
M.2		X	X			African		X	
M.3		X	X			Indian	X		
M.4		X	X			Coloured	X		
M.5		X		X		African		X	
M.6		X	X			African	X		
M.7		X	X			African	X		
M.8		X	X			African	X		
M.9		X		X		African			X
M.10		X		X		African	X		
M.11		X		X		African		X	
M.12		X	X			Coloured	X		
M.13		X		X		Coloured			X
M.14		X		X		Indian			X
M.15		X	X			Indian	X		
M.16		X	X			African	X		

Key

M= Midwife

F= Female

5.2.2 Demographic profile of gynaecologists

The researcher had intended to interview gynaecologists only. However, when she got to some of the facilities, she found out that gynaecology services at one of the district facilities were provided by medical officers. The medical officers are providing gynaecological services due to shortages of gynaecologists in the public hospitals. As a result, the participants also included one medical officer. As depicted in Table 5.2 below, the participants included 1 medical officer, and 5 gynaecologists. The medical officer and the other three gynaecologists were males and only two of the gynaecologists were female. Most of the gynaecologists (4) and the medical officer's ages ranged between 20 and 40 years and only 1 was between 41 and 60 years. All the gynaecologists were Africans, and the medical officer was Indian. The work experience of the

medical officer and the gynaecologists range from 0 to 10 years with the medical officer and two gynaecologists having experience of between 11 and 20 years and three gynaecologists with experience of 10 to 20 years.

Table 5.2: Demographic profile of gynaecologists

Participant No.	Gender		Age (years)			Race	Work experience		
	M	F	20-40	41-60	61-80		0-10	11-20	21-30
MO.1	X		X			Indian	X		
G.1	X			X		African	X		
G.2	X		X			African		X	
G.3		X	X			African		X	
G.4	X		X			African	X		
G.5		X	X			African		X	

Key

MO = Medical Officer

G = Gynaecologist

M= Male

F= Female

5.2.3 Demographic profile of women with disabilities

The researcher employed the criterion sampling strategy to sample 12 participants from WWDs. Of the 12 WWDs, 4 had a physical impairment, one had both physical and visual impairments. The participants also included 4 women with hearing impairments. Four of the participants had a visual impairment. Of the 4 women with a visual impairment, 1 woman also had albinism. The women were aged from 18 to 48 years. Six were aged between 28 and 38 years, 4 between 38 and 48 years, and 2 women between 18 and 28 years. All the women were African and not employed. One of the women was enrolled as an IT student at the eDeaf Association in Durban. Amongst the women, 4 were married while the other 8 were not married. In terms of

education, 1 woman did not have any formal education, 1 had primary education, 6 had secondary education and 4 had tertiary education.

Table 5.3: Demographic profile of women with disabilities

Participant No.	Age (years)			Race	Marital Status		Educational level				Employment status	Type of impairment		
	18-28	28-38	38-48		Y	N	None	P	S	T		Visual	Physical	Hearing
WWD.1		X		African		X	x				Not employed		X	
WWD.2	X			African		X				X	Student			X
WWD.3			X	African	x					X	Not employed			X
WWD.4		X		African	x					X	Student			X
WWD.5		X		African	x				X		Not employed			X
WWD.6		X		African	x				X		Employed		X	
WWD.7			X	African		X			X		Not Employed	X		
WWD.8		X		African		X			X		Not employed	X	X	
WWD.9			X	African		X				X	Employed	X		
WWD.10		X		African		X			X		Not Employed	X		
WWD.11	X			African		X			X		Not employed		X	
WWD.12			X					x			Not Employed		X	

WWD= Woman with disability:

Y = Yes N = No

P= Primary

S = Secondary

T = Tertiary

Using the Conceptual Framework of Assessing Access to Healthcare Services by Peters *et al.* (2008:169) outlined in Chapter 3, the results from the focus group discussion and interviewed data were categorised as follows: a) conceptualisation of access to maternal healthcare by WWDs, b) inhibitors of access to maternal healthcare services, c) facilitators of access to maternal healthcare services. These formed the main themes of the study (see Table 5.4), and each theme is discussed in detail in this chapter.

5.3 CONCEPTUALISATION OF ACCESS TO MATERNAL HEALTHCARE SERVICES FOR WOMEN WITH DISABILITIES

For the participants, access was a difficult concept to define. It includes the availability of the service, affordability and ability to get the service. Because the concept of access is difficult to define, most of the participants focused on the factors that impact access to maternal healthcare services for WWDs. The factors impacting access were broadly categorised as systemic, structural and personal factors. The systemic factors included availability of human resources, knowledge and competency to handle pregnant WWDs, information and communication needs of WWDs, availability of information on the management of pregnant WWDs, referral system for WWDs, health financing and multi-disciplinary approach. The structural factors that were highlighted in the interviews and focus group discussions include infrastructural design, examination beds and sanitary facilities. Lastly, the personal factors that relate to access include the ability to read and write, interaction between impairment and pregnancy, own experience with a person with a disability, availability of a companion, and attitudes of healthcare workers towards WWDs as well as attitudes of WWDs towards midwives.

The second section presents the inhibitors of access to maternal healthcare services. These inhibitors emanated from systemic, structural and personal factors. The last section outlines the facilitators of access which also emanated from the systemic, structural and personal factors. Verbatim from the

transcribed focus group discussions and one-on-one interviews is used to support the observations made by the researcher.

Table 5.4: Main themes and subthemes from group discussions with health workers and interviews with women with disabilities

Theme	Sub-theme	Category
1. Access to maternal healthcare services	1.1 Systemic factors	1.1.1 Availability of human resources
		1.1.2 Knowledge and competency to handle women with disabilities
		1.1.3 Information and communication needs of women with disabilities
		1.1.4 Availability of information on the management of pregnant women with disabilities
		1.1.5 Referral system for women with disabilities
		1.1.6 Health financing
		1.1.7 Multidisciplinary approach
	1.2 Structural factors	1.2.1 Infrastructural design and layout
		1.2.2 Examination beds
		1.2.3 Sanitary facilities
		1.2.4 Disability friendly scales.
	1.3 Personal factors	1.3.1 Ability to read and write
		1.3.2 Availability of a companion
		1.3.3 Interaction between impairment and pregnancy
		1.3.4 Own experience with a person with a disability
		1.3.5 Length of provision of service
		1.3.6 Health worker attitudes towards women with disabilities and women with disabilities' attitudes towards healthcare workers
		1.3.6 Empowerment of women with disabilities
2. Inhibitors of access to maternal healthcare services for women with disabilities	2.1 Infrastructural design	2.1.1 Internal arrangements and space availability
		2.1.2 Lack of accessible equipment and devices
	2.2 Lack of information on how to handle pregnant women with disabilities	2.2.1 Lack of understanding of the needs of women with disabilities
		2.2.2 Lack of training on how to handle women with disabilities

		2.2.3 Assumption that women with disabilities are high risk
		2.2.4 Marginalisation and stigmatisation
	2.3 Health worker acceptance	2.3.1 Health worker attitudes towards pregnant women with disabilities
		2.3.2 Attitudes of women with disabilities towards midwives
		2.3.3 Quality of maternal health services
	2.4 Cost of services	2.4.1 Additional expenses to access maternal healthcare services
		2.4.2 Transport cost
	2.5 Communication challenges	2.5.1 Lack of training on sign language amongst the healthcare workers
		2.5.2 Lack of sign language interpreters
		2.5.3 Lack of assistive devices
3.-Facilitators of access to maternal healthcare services.	3.1 Support from friends and family	3.1.1 Availability of a companion during hospital visits
	3.2 Availability of resources	3.2.1 Availability of a team of maternal healthcare service providers at all times
		3.2.2 Availability of disability-friendly equipment
		3.2.3 Availability of multidisciplinary team
	3.3 Experience	3.3.1 Having a family member with a disability
		3.3.2 Length of providing maternal healthcare services

5.4 THEME 1: ACCESS TO MATERNAL HEALTHCARE SERVICES

The study participants included women with physical, hearing and visual impairments, midwives, and obstetricians/gynaecologists. These participants understood access to maternal healthcare services as related to three main factors, which are a) systemic factors, b) structural factors and c) personal factors.

5.4.1 Systemic factors

Systemic factors alluded to by the participants included a) availability of human resources, b) knowledge and competency to handle WWDs, c) Information and communication needs for WWDs, d) availability of information on the management of pregnant WWDs, e) referral system for WWDs, f) health financing and g) multidisciplinary team.

5.4.1.1 Availability of human resources

Most of the healthcare workers described access to maternal healthcare services as dependent on the availability of human resources. The excerpts below are an illustration of how the healthcare workers described access in relation to human resources:

“During the process of delivery you must have people who are going to help you, for example, I delivered a patient who was “still”, so I couldn’t manage alone because when you are delivering a woman must lie down flat on the bed, you know, and she must open the legs, so I’ll have to get more midwives who are going to help me or either if there is a student midwife I will have to get them to help me to open the legs or otherwise I can use the poles to support the legs so that I can conduct the delivery.” (M.9: 53 years).

“Staffing is an issue because then the way you take care of them is not the same as the people who are fully normal and everything; with these ones, it’s not only like the patients would be doing most of the things on their own; some of them may have challenges walking, some can’t even wash themselves. So, if there’s only one sister like now I’m nursing 14 patients and I’m alone, so if I’ve five disabled patients...the staff shortage is an issue here”. (M.11: F: 40 years).

“Manpower is important”. (G.1: M: 47years).

5.4.1.2 Knowledge and competency to handle women with disabilities

The participants emphasised the importance of having knowledge and being competent to handle WWDs as an important element of access. A midwife from a regional hospital explained that it was a challenge to provide a service to a woman with a disability. In the excerpts below a woman with a disability and a midwife, emphasise the importance of knowledge to handle WWDs:

“The healthcare workers need to be sensitised on how to be disability-inclusive in the provision of maternal healthcare services... They should be provided with regular training because if the training is once-off they forget.” (WWD.7: 46 years).

“We should be sensitised because when you meet the pregnant woman it should be the last thing that we think about the disabled pregnant that oh wow she is disabled and now she is pregnant... It's added stress. Now how do I deal with the disabled part and how do I deal with the pregnant part?” (M.8: 35 years).

The lack of knowledge leads to the healthcare workers lacking confidence in providing services to WWDs as indicated in the excerpts below:

“The challenge is that I'm limited, and I feel a discomfort. I'm limited in my action, in my management and ultimately I feel like a bit discomfort...and I am a person who becomes confident when I do what I can do.” (M.12: 40 years).

“We do not know how to relate to them. You are not sure how to relate to her. I know how to relate to normal women. We are not confident to look after her. I will not be sure on what to do.” (M.10: 40 years).

5.4.1.3 Information and communication needs for women with disabilities

Access for women with hearing and visual impairments was related to the communication needs of the women with visual and hearing impairments. On

the other hand, the need for information regarding pregnancy and disabilities cuts across the different types of disabilities. The excerpts below show how access is related to the communication needs of women with hearing impairments:

“The very problem is communication...communication becomes difficult.”
(M.13: 35 years).

“There was a communication barrier, but I was able to communicate with a doctor using a pen and a paper...” (WWD2: 24 years).

“The communication with the nurses was really difficult and I asked my sister to come with [me] to the clinic...” (WWD3: 33 years).

Some healthcare workers explained that relying on a relative to interpret might mean that the healthcare workers do not get accurate information as noted in the quote below:

“I remember the first visit. It was a headache because of trying to establish when her period was. So, you had to ask the partner, and the partner was just laughing not being comfortable. We found out that the other information we could not get from the partner because it's either he is too uncomfortable to ask or he really does not understand maybe they didn't understand each other or something.” (M.7: 28 years).

Relying on the relative to interpret infringes on issues of confidentiality especially when it comes to informing the women with hearing impairments about other health conditions as explained below by a midwife from a district hospital:

“It is a challenge, especially when taking the history of the woman. You end up relying on the information that you are told by the relative. This is a challenge also in terms of confidentiality. For instance, if you need to tell the woman that

she is HIV positive. Then you have to inform the relative who will then communicate it to the woman. It is a challenge.” (WWD 4: 49 years).

The challenges of communication between the healthcare worker and the women with hearing impairments are worsened during delivery as there is no time for communicating using pen and paper. One midwife describes how they improvise sign language to try and communicate with women with hearing impairments in the excerpt below:

“When it comes to delivery we just do actions you see. We just design our own sign language. The advantage is that when the child wants to come out then naturally it forces the mother to push.” (M.10: 40 years).

The WWDs felt that they do not have adequate information available for them on their pregnancy and disabilities. This is because at times the available information is not in accessible formats or does not relate to their conditions. In the excerpts below, a woman with a hearing impairment and one with a visual impairment explain why they did not attend an antenatal clinic:

“I went to the antenatal classes once and there was no interpreter. I could not hear anything, so I decided not to go as I did not gain anything from the classes.” (WWD3: 33 years).

“At the antenatal class, they had pictures and used actions to explain to us how we breastfeed our kids. I could not see anything. It did not make sense for me to attend further.” (WWD9: 38 years).

5.3.1.4 Availability of information on the management of pregnant women with disabilities

Another factor that was associated with access to maternal services was the availability of information on the management of pregnant WWDs. This was affirmed by the excerpts below:

“In our profession, they should highlight and emphasise specific care for patients with disabilities and more detailed management.” (M.10: 40 years).

“And there is no clear written thing which specifies and that talks to disabled patients.” (M.7: 28 years).

5.4.1.5 Referral system for WWDs

Most participants indicated that WWDs need to be referred to higher levels of care, for instance, from a clinic to a district hospital or from a district hospital to a regional hospital because their disabilities may interact with their pregnancy which the lower-level facilities are not prepared to handle. This is outlined in the excerpts below:

“The women with disabilities differ from women without disabilities because their disabilities may interact with pregnancy. It is therefore imperative that they be referred to higher levels of care where they can benefit from a multidisciplinary team. However, the challenge is that pregnant WWDs are in most cases just provided with referral letters, and no transport is provided to them which makes them present late at the higher level of care.” (G1: M: 47 years).

“.... there is a need for an ambulance to be available every time because if the referred woman arrives late, there may be complications which may be difficult to handle.” (G2: M: 40 years).

5.4.1.6 Health financing

Some of the participants linked access to the health financing system of the country as outlined in the excerpts below:

“The good thing about the South African Health system is that it is free for pregnant women and children under five years. As a result, WWDs do not have

to deal with financial constraints when they need maternal healthcare services”.
(G1: M: 47years).

“For me, I am happy that I do not have to pay when I get to the hospital. I get all the treatment that I need free. I never go to private clinics or hospitals because private doctors are very expensive; I go to public facilities...” (WWD9: 35 years).

5.4.1.7 Multidisciplinary approach

The participants highlighted that to ensure access to maternal health services for WWDs, there is a need for a multi-disciplinary approach. The quotes below indicate how a multidisciplinary approach is important in the provision of maternal healthcare services for WWDs:

“We also use a multidisciplinary team so that we can better deal with the problem at hand – so, it’s not just us as midwives and obstetricians who are involved but also other specialties as well, depending on the problem at hand. For example, if we need orthopaedic doctors, we get them; if we need neurologists, we get them – if we need to get every specialist involved in the process depending on the condition, then we do that. It’s not that a patient sees one set of doctors, but every specialty is available to intervene. Psychologically, we get social workers involved as well because obviously, patients need to be counselled about their conditions.” (M15: 22 years).

“Providing maternal healthcare services to women with disabilities requires extra care and experience. It involves a multidisciplinary approach, social worker, occupational therapist, and other relevant medical disciplines.” (G3: M: 40 years).

5.4.2 Structural factors

Women with disabilities require facilities to be designed in such a way that they suit their specific needs. The structural factors identified include a) infrastructural design and layout, b) examination beds, c) scales and d) sanitary facilities.

5.4.2.1 Infrastructural design and layout

The participants highlighted that the design and the layout of the facilities impact access for WWDs. The following excerpts highlight infrastructural issues raised by the participants.

“To improve the environment for women with things like the toilets or bathrooms...must have those rails where they can hold on.” (M8: 40 years).

One of the medical officers from a district hospital explained that there is a lot that needs to be done to transform the institutions into disability-friendly facilities. Below is what he had to say:

“Simply, access to the facility is difficult. In one of the clinics, ramps were not available. We had student nurses to carry a woman with a physical disability up and down the stairs. At this hospital, we have a ramp, but one has to go around the whole facility to use the ramp and access the maternity ward.” (MO.1: M: 38 years).

In the excerpt below, one of the gynaecologists at a provincial hospital also shared the sentiments of the medical officer:

“The passage is very narrow, just this week we had a woman with a visual impairment who bumped onto one of the chairs and almost fell. We had to accompany her out because we thought at least as soon as she gets out she knows her way.” (G5: F: 37 years).

One of the women with a physical impairment explained her challenges with going to the 8th floor during load-shedding and the lifts were not working. Her frustrations are outlined in the excerpt below:

“The nurses had to come down and help me on the ground floor instead of using maternity ward which is on the 8th floor I could not use the stairs.” (WWD11: 27 years).

5.4.2.2 Examination beds

Healthcare workers stated that WWDs require adjustable examination beds. However, the challenge is that some of the facilities do not have adjustable examination beds. Below are some excerpts from some of the midwives explaining that their institutions did not have adjustable beds:

“The types of examination beds that we are using are not conducive to disabled people because the ones for the disabled people are supposed to be at the lower level, but ours are up.” (M12: 35 years).

“The facility will be disability-friendly if we can be provided with adjustable beds for the physically disabled.” (M4: 40 years).

A woman with a physical disability also confirmed this in the extract below:

“Because I have one leg, it was difficult for me to climb onto the bed. I had to be assisted by the nurses... they had to physically carry me.” (WWD8: 34 years).

In addition to the adjustable beds, one of the midwives commented that because of the nature of some disabilities they may need cot beds for adults which in some instances are not available as indicated in the excerpt below:

“We do not even have a single cot bed yet we at times receive women with paralysis of one side. You can find these cot beds in surgical wards but not in the maternity ward.” (M14: 40 years).

The lack of accessible necessary equipment cuts across the different maternal health services levels of care except for the national hospital. A midwife who has previously worked at a clinic and is now working at a regional hospital explained in the quote below that the beds that they use at the hospital are similar to those that they used at the clinic.

“The equipment is the same. It’s the same equipment that we use at the clinic, which we also use at the hospital. Like the beds, you find that they do not move up and down. Sometimes you have to carry people from wheelchairs onto the bed.” (M7: 28 years).

However, a midwife at the national hospital explained that they had the required resources to use for WWDs and this is noted in the quote below:

“The beds are disability-friendly because we’ve electric beds – the bed can go up and it can go down...you can move yourself up or you can even change the position of the bed according to how you want it to be. In addition, the hospital has the aids, they are available here in the ward which will enable you to be able to use.” (M15: 22 years).

5.4.2.3 Disability-friendly scales

Women with physical impairments cannot stand on the normal scales to check on their weight. One of the midwives from the regional hospital explained that they did not have to weigh the women who are wheelchair-bound because they did not have suitable weighing equipment. This is confirmed by the excerpt below:

“.... sometimes they would not weigh her. We would just send her for an ultrasound. So, you find that the care that she will get will not be of proper quality. Because we are actually supposed to measure the baby, see the presentation.” (M7: 28 years).

A midwife stated that they have coined a term for the physically impaired women in wheelchairs. Instead of writing the weight of the women they just write, *“wheel-chair bound”*. (M7: 28 years).

In the quote below, a midwife from a provincial hospital explains that the only scales that they have are those for women without disabilities:

“Scales...we do not have any that cater for women with physical impairments, like the ones we are using here...it is for a person who can walk”. (M12: 35 years).

One of the women with a physical disability stated that she was never weighed during her pregnancy as noted in the quote below:

“They did not weigh me. They would do the other check-ups but because I could not stand on the scale, I was never weighed.” (WWD11: 27 years).

5.4.2.4 Sanitary facilities

The study revealed that another inhibitor of access was that the bathrooms and the showers are not designed for WWDs. One of the healthcare workers from a community healthcare centre stated that their bathrooms and toilets were not suitable for WWDs and that the rails were not available:

“Our bathrooms are either a shower or tub, they do not have rails that you can hold onto. This is a challenge for women with disabilities as the rails to hold onto are essential for them during bathing”. (M1: 53 years).

One woman with a physical disability below also affirmed this in the excerpt below:

“Bathing was a problem for me especially because I have one leg and I cannot see. I needed something to hold onto but there was nothing. I relied on the nurses to assist me.” (WWD8: 34 years).

5.4.3 Personal factors

The study also revealed that personal factors impact access to maternal healthcare services for WWDs. These factors include a) ability to read and write, b) availability of a companion, c) interaction of disability and pregnancy, d) own experience with a person with a disability and e) healthcare worker attitudes toward WWDs and WWDs attitudes towards healthcare workers.

5.4.3.1 Ability to read and write

The ability to read and write was essential in ensuring access to maternal healthcare services especially for women with hearing impairments. Both WWDs and healthcare workers indicated that most facilities did not have sign language interpreters and communication was made easier where the women with hearing impairments could read and write. This is confirmed in the following excerpts:

“There was a communication barrier, but I was able to communicate with a doctor using a pen and paper.” (WWD2: 24 years).

Below a midwife explains that communication with women with hearing impairments who can read and write is relatively easy:

“But you know with those who can read and write it is easier. You just know that with this client you communicate through writing.” (M8: 33 years).

5.4.3.2 Availability of a companion

For WWDs, access to maternal services is also related to the availability of a companion. This is essential for women with physical impairments, for women with visual impairments, and for women with hearing impairments as indicated in the excerpts below:

“So, she used to come for antenatal visits. She used to come with her partner, and she did not know how to speak sign language. So, like you would find out that when you were talking to her you had to tell the partner”. (M10: 28 years).

“My partner had to assist the hospital sister to carry me onto the examination bed. It was difficult for me to get onto the bed on my own.” (WWD11: 27 years).

“The hospital has so many stairs and it is difficult for me as I am visually impaired. My sister helped me to move from one place to another.” (WWD6: 35 years).

5.4.3.3 Interaction between impairment and pregnancy

The study also found out that at times pregnancy interacted with the impairment which resulted in challenges in the provision of services to pregnant WWDs. This is clearly outlined in the quote below:

“Challenges differ from person to person because sometimes a person whose paraplegic may pose different challenges from a person who has cryptococcosis. The challenges differ according to a person’s condition. So, with a paraplegic person, there’re more challenges because, firstly, you’ve to forget just being a midwife as you’ve to nurse a person like to start with assisting the basic nursing care like everything because some of them can’t even take a glass of water and drink; so, you’ll do everything for the person.... sometimes it also impacts on staffing because that patient...some of the patients...like most of the time they need a second person because you can’t do everything

on your own...so you need another person to help you in assisting the patient.” (M16: 49 years).

“Woman with disabilities is a higher risk to us because you don’t know how the change in the body will affect her. So, the risk is not uniform across the spectrum. With women who have visual and hearing impairments, the risk is relatively low. However, with women with physical impairments, sometimes the growth of the baby starts affecting how they walk...then they start to feel increased pains. Sometimes the body doesn’t allow the growth of the baby and the baby will end up coming prematurely then because we have to deliver the baby at a certain age. This is because if we let the baby grow further, there’s no space; like the one woman we had who had a spine problem.” (M15: 22 years).

5.4.3.4 Own experience with a person with a disability

The study also revealed that the healthcare workers indicated that their own personal experiences with people with disabilities helped them in understanding the needs of pregnant WWDs. In the excerpts below some midwives explain that having a relative with a disability helps them to understand and accept WWDs:

“By the way, I have a brother who is also disabled. He was born in the 1970s...then he had this poliomyelitis. So, when I was born at home there was this person. So, to me being disabled does not mean there is something wrong with you. I can relate with the people with disabilities and have some understanding of the issues that they face.” (M9. 53 years).

“I also have a son who has disabilities. That has given me an understanding of how to treat other people with disabilities” (M13: 49 years).

5.4.3.5 Length of provision of service

The study revealed that the length of maternal healthcare service provision also made the maternal service providers more experienced and better prepared to handle WWDs. In the excerpt below, a health worker explains that the provision of maternal services to WWDs is enhanced by the fact that she has been providing maternal healthcare services for a long time.

In the beginning, I'm sure there were definitely challenges even though I can't remember the nature of these challenges because it's a bit long time...but now providing maternal health services to women with disabilities has become an everyday thing. I think because I'm used to managing them now. Most of the hospitals transfer them to our hospital – To me it's now like helping any other patient; it's not really a challenge (M16: 49 years).

In order to build confidence amongst the new midwives, they partner them with more experienced midwives. See quote below:

“Even if there are new midwives, we always allocate them an experienced staff so that they don't panic when they come across with something they don't know. In so doing the new midwives can learn...so that they can get used to the handling of situations.” (M15: 22 years).

5.4.3.6 Attitudes of healthcare workers towards WWDs and attitudes of WWDs towards healthcare workers.

The participants also revealed that access to services is determined by the attitudes of healthcare workers towards WWDs. Some of the excerpts below indicate how attitudes of healthcare workers have a bearing on access:

“As I arrived at the clinic for the very first time, they asked, “mm, even this one gets pregnant, she loves boys. For my second pregnancy, I then decided to go to hospital x to avoid meeting the same nurses.” (WWD11: 42 years).

“We are not saints in this. I think we are always unfair to them. There is always an unspoken word that we have for them. It is like, they are not supposed to have children. We see many pregnant women, but we do not ask them how they look after their children... but with this blind woman, because it was her third pregnancy, I felt obliged to ask. I think they (the women with disabilities) feel it and that’s why we do not see them for other services but only come when they are pregnant, and they present late because they cannot avoid the healthcare during pregnancy.” (G5: F: 37 years).

In some instances, the participants revealed that the attitudes of WWDs towards maternal healthcare workers impact access. Below, two midwives from two different facilities describe how they felt that some WWDs did not like being attended to by midwives:

“And I remember that her attitude used to be unfriendly, but we could understand. We thought that maybe because she did not want to be looked at. But when she got in, she did not want the nurses to see her. She knew that she came for the doctors. So, it kind of hindered us because we really wanted to find out what happened to her and also check the file and see if when they did the ultra-sound what is wrong with the baby, but she used just to be there.” (M7: 28 years).

“You try to explain but it seems as if she doesn’t understand you but the moment the doctor comes in with a stethoscope over her, she will understand. Her reaction will change totally.” (M10: 39 years).

5.4.3.7 Empowerment of women with disabilities

Both healthcare workers and WWDs indicated that being able to voice your concerns was related to access for WWDs as noted in the quotes below:

“The nurses at the hospital know me. When I need something, I clearly tell them, and they do it for me. I am happy that they understand me.” (WWD8: 34 years).

“It is easier for those who have their voice and can stand up for themselves. They can get the services they need. However, most of them are voiceless. The healthcare workers need to understand that some of the women with disabilities do not speak out for themselves and try and help them as much as possible.” (G5: F: 37 years).

5.5 THEME 2: INHIBITORS OF ACCESS TO MATERNAL HEALTHCARE SERVICES FOR WOMEN WITH DISABILITIES

The participants identified some of the inhibitors of access as including a) infrastructural design, b) lack of information on handling pregnant WWDs, c) health worker acceptance, d) cost of services, and e) communication.

5.5.1 Infrastructural design

The two major categories that emerged under infrastructural design include internal arrangements and space availability and lack of accessible equipment.

5.5.1.1 Internal arrangements and space availability

The study revealed that the maternal health institutions were not designed with consideration of the WWDs. The passages are narrow; some of the institutions have staircases and small consultation rooms. Below are the excerpts that affirm that internal arrangements and space availability are an inhibitor of access to maternal healthcare services for pregnant WWDs:

“I was thinking...eh we are having a problem of lifts that are on and off; if it happens that the patient is in labour, and the lifts are not working...when we push for the maximum we can do, there is a time that a patient can take stairs and then you think what can happen if the patient is obliged to take stairs, you know...and then I further thought what about those who use wheelchairs, for instance, if it happens that they need to use wheelchairs to actually reach where they need to go.” (M10: 45 years).

“When she had to go to the toilet, the doors were a bit small for the wheelchair, but then she was able to squeeze in.” (M11: F: 49 years).

In the quote below, one of the WWDs explained how narrow passages were a problem for her at the Community Healthcare Centre.

“I had a problem. Um my wheelchair, it could not fit into the consultation room. The nurse had to come and see me in the passage, and I was then told to go to hospital X for my next visit.” (WWD11: 35 years).

In the excerpt below one of the midwives also notes that the stairs could be a challenge even for women with visual impairments:

“If the person is blind, for instance, it is easy to get where you want to get when it’s just an open space...on the ground floor...as compared to taking stairs. For the blind, it is important to know where you are going...you need to know. Going through the stairs is a bit challenging.” (M10: 40 years).

5.5.1.2 Lack of accessible equipment and devices

Women with disabilities require equipment that is accessible or custom-made in such a way that they can use it without problems. However, one of the challenges that WWDs face is the lack of accessible equipment and devices. The excerpts below outline the issue:

“We had a client who was wheelchair-bound. It was difficult to assess whether is she gaining weight is the baby growing. She was very obese. I remember she would be on the wheelchair it was a mission to carry her out of the wheelchair. Because the wheelchair is here and the bed up there.” (M7: 28 years).

“We do not have a have beds with a bell which especially would be useful for the woman with a visual impairment. She would just ring a bell and is assured that the healthcare worker has heard her.” (M14: 53 years).

In the excerpt below, one of the WWDs explains how she struggled to get on the bed on her own because the bed was too high.

The beds are so high and with one leg it's a mission to get on them. The healthcare workers have to assist. (WWD11: 35 years).

5.5.2 Lack of information on how to handle pregnant women with disabilities

Healthcare workers expressed concern over the lack of information on how to handle pregnant WWDs. The categories that came out of this sub-theme include lack of understanding of the needs of the WWDs, assumptions of risk, and stigmatisation and marginalisation.

5.5.2.1 Lack of understanding of the needs of women with disabilities

In the excerpts below, healthcare workers describe how lack of information leads to them not understanding the needs of pregnant WWDs:

“The medical school curriculum is not structured to ensure that we are able to integrate the women with disabilities into western medicine. We as healthcare workers are ignorant as well as the society in such a way that I feel the lack of understanding of the needs of pregnant women with disabilities results in their discrimination.” (G5: F: 37 years).

“And there is no clear written thing which specifies and that talks to pregnant women with disabilities. So as midwives we treat them as other women without disabilities. Because we do not know how to handle them, in most cases we refer them to levels of high care.” (M7: 28 years).

“Because I do not understand the needs of women with disabilities, I feel like there is a lack somewhere somehow...you have to do it to support... I wish I could do something to support WWDs but I do not understand their needs. (M10: 40 years).

One woman with a visual impairment explains how she thinks that healthcare workers do not have information that they too are normal human beings who can get pregnant. See the excerpt below:

“It surprises the healthcare workers that we get pregnant. It’s like we do not have functional reproductive systems. They need to be educated that we too have functional reproductive systems, and it is normal for us to be pregnant as we are women too.” (WWD9: 38 years).

5.5.2.2 Lack of training on how to handle pregnant women with disabilities

Another inhibitor of access to maternal healthcare services cited by the healthcare workers was the lack of training that prepares them adequately on how to handle pregnant WWDs. Below are some of the excerpts where health workers stated that lack of training on handling WWDs was a challenge for them:

“It’s added stress now, how do I deal with the disabled part and how do I deal with the pregnant part. I think if we are sensitised during training at school to be made aware to that how to communicate with them and their needs, how to meet their needs and stuff maybe it will, because if we are more empowered then we know there won’t be that much fearful and then we are more likely to treat them and manage them and they will get proper healthcare.” (M7: 28 years).

“We are not adequately prepared to deal with pregnant women with disabilities.” (M13: F: 43 years).

5.5.2.3 Assumptions that women with disabilities are high-risk patients

Lack of information on how to handle WWDs results in WWDs being regarded as high-risk patients even when they are not. A midwife who previously worked at the clinic explains in the quote below that whenever they encountered a woman with a disability, they would refer her to a high-risk facility:

“When we see a disabled woman, we say ok she is a high-risk patient, so she has to go and be seen at a high-risk facility.” (M7: 28 years).

A woman with a physical disability explains below how she was referred from a community healthcare centre to a regional hospital:

“The nurses from the clinic said I should go to hospital X because they do not know what caused me to stroke even though the stroke happened when I was 5 years old.” (WWD1: 29 years).

5.5.2.4 Marginalisation and stigmatisation

Some of the WWDs stated that sometimes they felt stigmatised and marginalised by the way they were treated by the healthcare workers. One woman with a hearing impairment explains how she thought the midwives were ignoring her because of her impairment. See the excerpt below:

“It was a very difficult time; some of the hospital nurses would just ignore. I felt the nurses were ignoring me maybe because I’m deaf and they were attending the hearing patients...They gave the hearing women fair treatment, but they were ignoring me because of my deafness.” (WWD3: 33 years).

A woman with albinism and partial visual impairment explains how the healthcare workers were saying she loves men and keeps getting pregnant as if she is not supposed to get pregnant. Below is an excerpt of what she said:

“As I arrived in the health facilities – again – I faced the same challenges from the nurses who kept on saying “mm, are you pregnant again and you are here to give birth again?” You know, “albinos just like to have children and they love men” (WWD11: 42 years).

One of the midwives explains how she felt that sometimes the WWDs could not get some of the services because of the impairment:

“I believe it is frustrating as well for the women and they think there’s something that should be done for them, but it cannot be done because of who they are and what they have”. (M13: 40 years).

5.5.3 Healthcare worker acceptance

Health worker acceptance was also one of the factors that were identified as inhibitors of access. Under healthcare acceptance the categories include a) staff attitudes towards WWDs, b) attitudes of WWDs towards midwives, and c) quality of maternal healthcare services.

5.5.3.1 Staff attitudes towards pregnant women with disabilities

Negative staff attitudes were cited as having a negative impact on access to maternal healthcare services. This is outlined in the excerpts below:

“We have these unspoken words which reflect in the way we treat them. When we attend to them quicker, it’s like we are saying let us help them so that they quickly go so that even the other community members do not see them. In a way, we are saying it is abnormal for them to be pregnant. I feel we do not go an extra mile in a way that we should in order to treat them and understand that it is normal for them to be pregnant” These women can sense it and may not want to interact with us as health workers. (G5: F: 35 years).

“Because at Hospital X I felt that they did not understand that I too can have babies and kept on asking that and mocking me about it, I then decided to go to Hospital Y for my second baby. However, at Hospital Y still, there were nurses who were saying I love men too much that is why I keep getting pregnant” (WWD11: 42 years).

5.5.3.2 Attitudes of women with disabilities towards midwives

At times the WWDs preferred to be examined by gynaecologists and not midwives. Yet gynaecologists are not always around, and the midwives would not be able to do their work properly. This is outlined in the excerpt below:

“But when she got in, she did not want the nurses to see her. She knew that she came for the doctors. So, it kind of hindered us because we really wanted to find out what happened and help her in any way we could” (M7: 28 years).

“There are those women who feel that we as nurses cannot help them. We say something they do not listen but if the same thing is said by the gynaecologist then they understand.” (M11: 39 years).

5.5.3.3 Quality of maternal health services

In as much as the maternal healthcare service providers try their best to provide good quality services, most of them perceived the quality of services as poor. The healthcare workers attributed the poor quality mainly to lack of disability-friendly resources, communication challenges and lack of knowledge on how to handle pregnant WWDs. Some of the WWDs also expressed their concern over the poor-quality maternal services leading to change facilities. This is outlined in the excerpts below:

“In hospital where I delivered my baby, they ignored me and said you will deliver on your own and keep on crying like that” and finally I had to have an operation because I had felt severe labour pains and the baby was tiredBecause my first born almost lost his life at hospital A because of their negligence; I then

decided to change the address in order for me to deliver at X". (WWD11: 42 years).

"I wouldn't like to lie, the quality of services that we provide to the women with disabilities is very poor. It's not like the one we provide to women without disabilities is good. Because the one we provide to the women with disabilities is not good, it is worse off for women with disabilities as the women with disabilities need us to go an extra mile because of their needs." (G5: F: 36 years).

"I think the quality is not a good one...although we're trying by all means to help them, but I do not think they get the care they deserve...like in my case if there was no doctor who was able to talk sign language which means we could've taken that woman to the theatre without saying anything to her so I think it's not enough." (M11: 35 years).

5.5.4 Cost of services

While WWDs incur challenges similar to women without disabilities, the WWDs incur additional expenses such as seeking other services as well as the need to bring other people to assist them. The sub-themes that emerged include a) additional expenses to access maternal healthcare services and b) transport costs.

5.5.4.1 Additional expenses to access maternal healthcare services

For WWDs to manoeuvre around the facilities, they need to be accompanied by a relative who will assist them. In the excerpt below, a midwife explains how a woman with hearing impairment always had to bring her partner to the facility:

"So, she used to come for antenatal visits. She used to come with her partner. And she did not know how to speak sign language. So, like you would find out that when you were talking to her you had to tell the partner". (M7: 28 years).

One woman with a hearing impairment explains that she was requested to bring a relative whom the healthcare workers could communicate with. See the quote below:

“They said “we cannot communicate with the deaf, you must come with the person...maybe your boyfriend or your sister so that they could interpret for you--that was the nurses.” (WWD2: 24 years).

In the excerpt below, one woman explains how she has additional costs as they need to always have someone to assist them during a hospital visit:

“As I am blind and have one leg, when I need to go to the clinic for post-natal care, I need someone to accompany me to take carry the baby for me. This means I need transport fees for two people.” (WWD7: 38 years).

5.5.4.2 Transport costs

Referrals to high care facilities may increase the distance travelled by WWDs, thereby increasing the cost of accessing healthcare services. This was articulated by some health workers in the excerpts below:

“It’s just that we as midwives, we have a tendency, I am not sure whether it’s a tendency or it’s because we are supposed to see the normal pregnant patients. Once you see that there is something that is not your normal ambulance patients, then you refer to high-risk clinic. Because the referral is not an emergency, we just tell them to go on their own.” (M7: 28 years).

A midwife at a community healthcare centre explains that they could not assist a pregnant woman in a wheelchair. They had to refer her to a regional hospital as outlined in the excerpt below:

"We also had one case who was on a wheelchair. I was not examining that client. I do not know what was wrong with her. But they could not examine her. We ended up referring her to the regional hospital because we couldn't examine her, and she had to go on her own." (M6: 35 years).

The Medical Officer also explained that the challenge is that we just let them and tell them to find their way to the next level of care without even considering that they come from a disadvantaged population that may have economic challenges. This is noted in the quote below:

"When we see a woman with disability, we tell them they are supposed to go to a higher level of care and we do not the means of getting to next level of care. We know that they are a disadvantaged population which is disproportionately affected by poverty and at times do not have access to grants" (MO1: 35 years).

5.5.5 Communication challenges

Both maternal service providers expressed the challenges in communication especially with women with hearing and visual impairments. Although the women with visual impairments did not talk about the communication challenges, the women with hearing expressed so much concern about the communication issue. The two categories that emerged were a) lack of training in sign language, b) lack of sign language interpreters and c) lack of assistive communicative devices.

5.5.5.1 Lack of training on sign language

The study also found that access to women with hearing impairments was a challenge due to the lack of sign language training amongst healthcare workers. This is articulated in the following excerpts:

"The fact that I cannot even greet in sign language is really an issue. It really means I am not prepared to receive a person with a hearing impairment. I feel it makes them feel unwelcome." (G5: F: 37 years).

“Let’s say the person is deaf and dumb...we’re not trained to communicate with deaf people, and it becomes unfair to them when you tell them that I don’t understand you” and you can see they get frustrated, shame, when you say “I can’t hear you I don’t understand”. (M11: 49 years).

Women with hearing impairments expressed the same sentiments that lack of training in sign language amongst the healthcare workers makes access to maternal services frustrating. See the quote below:

“Healthcare workers need to be able to communicate with the deaf because it’s very difficult to communicate with them because it’s very tiring to always arrive and have to communicate using a pen and paper. In government hospitals maybe if they can train nurses in South African Sign Language that would ease the communication problem”. (WWD 2: 24 years).

“They need to teach nurses sign language, or we can teach them sign language maybe the basics such as “hello”. (WWD3. 33 years).

The healthcare workers noted that the ability to communicate in sign language enhances access to maternal healthcare services. One of the midwives describes how they were able to communicate with one woman with hearing impairment because there was a doctor who understood sign language. See the quote below:

“Fortunately for us, there was a doctor who was from Iraq and that doctor was able to talk sign language...so he was able to explain to her everything that was going to be happening in the theatre of which she was very cooperative. If he was not there, we would have sent the woman to the theatre without explaining to her what was going to happen to her” (M13: 40 years).

5.5.5.2 Lack of sign language interpreters

The participants also indicated that a lack of sign language interpreters acts as a barrier to access to maternal services. The sign language interpreters would make communication easier between the healthcare workers and the women with hearing impairments. This is explained in the excerpts below:

“We cannot communicate with the deaf, you must come with the person...maybe your boyfriend or your sister so that they could interpret for you...that is what the nurses said”. (WWD3: 33 years).

“Please, please, please, we need interpreters...there’re no interpreters and also in clinics there’re no interpreters there...but hoping that everything will be improved.” (WWD2: 24 years).

Since most facilities do not have sign language interpreters, midwives indicated that sometimes they do not get all the information that they need from women with hearing impairments. In addition, the healthcare workers have challenges in giving women the information that they need to give to women with hearing impairments. One of the midwives explains how it was a challenge to get some information from the partner of the woman with a hearing impairment, as the partner was not comfortable with the subject under discussion. See the quotation below:

“We found out that the other information we could not get from the partner because its either he is too uncomfortable to ask, or he really doesn’t understand maybe they didn’t understand each other or something.” (M8: 40 years).

In the excerpt below, a midwife explains how sometimes she can tell that there is communication breakdown because of messages being interpreted wrongly:

“Sometimes you see by the participant’s response. You can tell that the response is not for what you asked for.” (M3: 34 years).

However, the study found that in instances where women with hearing impairments could read and write, communication was much easier. For women with hearing impairments, the ability to read and write eased the communication barrier between them and healthcare workers. One of the women with a hearing impairment explains that communication was easier as she was able to read and write:

“There was a communication barrier, but I was able to communicate with a doctor using a pen and paper.” (WWD2: 24 years).

“But you know with those who can read and write it is easier. You just know that with this client you communicate through writing.” (M3: 33 years).

The study also revealed that good communication with WWDs leads to the development of trust relations between the healthcare worker and WWDs. The WWDs will be able to tell the healthcare workers whatever they need which will assist the healthcare workers to provide the required healthcare. One of the midwives explains the importance of a good relationship with WWDs. This is explained in the excerpt below:

“I’m able to communicate with my patients and also meet them ...what is it that you need right now – we’re able to counsel our patients and also build rapport with our patients that they can trust us enough to report if there’s a problem and we can do something about it immediately”. (M16: 49 years).

Furthermore, WWDs appreciated it when the healthcare workers were willing to learn to communicate with them. The women would then have a good relationship with the healthcare workers and trust them. In the excerpt below a woman with a hearing impairment explains how she appreciated a midwife who requested to be taught sign language.

“So, the nurse gave me some medication for fever and headache. The nurse then asked me if I could teach her sign language because it was her first time she had met a deaf person at the clinic. I really liked her. If all nurses could be like her. She paid attention to me and was prepared to learn sign language so that she would be able to communicate with me.” (WWD 3: 33 years).

5.5.5.3 Lack of assistive communicative devices

Healthcare workers felt that communication with the women with hearing impairments could be improved in the maternity wards by having a bed with flashlights. When the woman requires help, they could just switch on the light that flashes and then the midwife can see that the woman needs help. For women with visual impairments, healthcare workers felt that beds with bells would help as outlined in the quotes below:

“The labour ward does not have a single bed with a flashlight. This would be useful for a woman with a hearing impairment. When they need help, they could just switch on the flashlight to get the attention of the health workers. (M13: 49 years).

“We do not have beds with a bell which especially would be useful for the woman with a visual impairment. She would just ring a bell and would be assured that the healthcare worker has heard her.” (M14: 53 years).

5.6 THEME 3: FACILITATORS OF ACCESS TO MATERNAL HEALTHCARE SERVICES

For facilitators of access two sub-themes emerged. These themes included a) support from friends and family, b) availability of resources, and c) own experience with people with disabilities. The categories of each sub-theme are explained in the following paragraphs.

5.6.1 Support from friends and family

Most WWDs and healthcare workers stated that one of the enhancers of access to maternal healthcare services was support from family and friends. The prominent category was the availability of a companion during hospital visits.

5.6.1.1 Availability of a companion during hospital visits

The healthcare workers felt that if the women came with their partners, it made it easier for them to navigate the health facilities. At times they can interpret for the women with hearing impairments. Below are excerpts from some of the midwives and WWDs describing how having a companion facilitated communication between healthcare workers and the women with hearing impairments:

“The mom who could not speak had a relative with her. She knew a little bit of sign language so she could interpret for her. We managed to communicate through her relative.” (M2: 35 years).

“The communication with the nurses was really difficult and I asked my sister to come with [me] to the clinic.” (WWD3: 33 years).

In addition, another midwife stated that the presence of a partner assisted the woman with a hearing impairment to navigate through the facility. See below quote:

“She came with a partner who could see. So, the partner was leading her. She could talk, you know, but with queues and other things, the partner was guiding her.” (M5: 45 years).

Furthermore, in the quote below, another midwife explains that relatives assist women with physical disabilities to get onto the examination beds:

"I asked the relative to help because she could not put her leg on the foot stool. It was difficult for her. So, I asked the relative to help me carry her so that we could put her on the bed." (M1: 32 years).

5.6.2 Availability of resources

Participants noted that the availability of infrastructural and human resources enabled access to maternal healthcare services for WWDs. In terms of availability of resources, the two sub-themes that emerged are a) availability of a team of maternal healthcare service providers at all times b) availability of disability-friendly resources, and c) availability of a multidisciplinary team.

5.6.2.1 Availability of a team of maternal healthcare service providers at all times

Women with disabilities require the support of many healthcare workers. The healthcare workers stated that working as a team to support WWDs enhances access to maternal healthcare services. The excerpts below indicate how the availability of a team of healthcare workers enhances access to maternal healthcare services:

"As much as we sometimes have challenges related to short staffing, but for us, I can vow and say that our patients do receive quality healthcare because nursing-wise, they do get proper nursing care because we have adequate staff most of the time" (M16: 42 years).

"If it's a disabled person you need two or three people and there are always two or three people on duty there has never been a situation where there's less than that; so, we've enough manpower to adequately handle women with disabilities." (M15: 22 years).

Since disability interacts with pregnancy to pose challenges for access to maternal healthcare services for WWDs, the team of maternal healthcare providers should also be complemented by a multidisciplinary team.

5.6.2.2 Availability of disability-friendly equipment

The availability of disability-friendly equipment and assistive devices make maternal services easily accessible for WWDs as explained by one midwife. This is outlined in the quote below:

If you do have a disability...the aids, are available here in the ward which will enable you to be able to use...but if, for any reason, maybe you can't that's when healthcare workers can help". We have different kinds of assistive aids to help women with different types of disabilities." (M15: 22 years).

5.6.2.3 Availability of a multidisciplinary team

In the excerpts below, midwives explain how the provision of comprehensive services is enhanced by the availability of a multidisciplinary team all the time:

"We need to involve other specialties, you know, because we work hand in hand. While our obstetrics and the Gynae Department were going to be enough for normal patients, however, for women with disabilities, then we've to involve another specialty to be part of our management and these specialists are always available." (M10: 40 years).

"We also have to be able to deal with that but if you've enough experienced staff on the floor to manage the situation and that's one thing that we've at our disposal – our doctors are always available, so that helps us a lot because if a patient has some complications, the doctors are always readily available...unlike in other hospitals, for us, doctors are available 24 hours... if there's a need for a physio, our doctor orders a physio for physiotherapy; so, if there's a symptom of some neuro-physiological issues, then we do a consult to involve a Neuro-Physiotherapy Department." (M2: 49 years).

The need for a multidisciplinary team is also emphasised by a midwife from a provincial hospital who suggests that WWDs should have a facility offering comprehensive services including their impairments. See the excerpt below:

“If there’re particular facilities that deal specifically with people with disabilities...so, for example, if there’s an institution that’s dealing with hearing...or...loss of sight, or limited mobility or anything...not only focusing on that but also having a section of obstetrics and gynae section for that particular patient, rather than them going to general facilities. This will help to ensure that that the pregnant women with disabilities get the services in one place.” (M10: 40 years).

5.6.3 Experience with people with disabilities

The study found out that experience whether through having a relative with a disability or having worked for a long time with WWDs enhanced an understanding of the needs of people with disabilities. The two subthemes that emerged include a) having a family member with a disability, b) length of providing maternal healthcare services.

5.6.3.1 Having a family member with a disability

In the excerpts below, some of the healthcare workers indicated that they had a better understanding and could relate better with WWDs as they also had relatives who had disabilities:

“Having a brother who has a physical disability has helped me a lot. So, for me that experience makes me understand and makes me be comfortable than any other person.” (M9: 53 years).

“Living with my son who has disabilities has given me an understanding of how to treat other people with disabilities. I can relate to them easily and we can easily understand each other” (M13: 49 years).

5.6.3.2 Length of providing maternal healthcare services

A health worker explains that the provision of maternal services to WWDs is enhanced by the fact that she has been providing maternal healthcare services for a long time. Below is what she had to say:

In the beginning, I was not comfortable. I had fear...but now providing maternal health services to women with disabilities has become an everyday thing. I think because I'm used to managing them now as I see them frequently. Most of the hospitals transfer them to our hospital – to me it's like helping any other patient; it's not really a challenge (M16: 49 years).

As experience is important, some facilities partner new midwives with the more experienced ones to build confidence amongst the new midwives. This is outlined in the excerpt below:

“Even if they're new ones, we always allocate them an experienced staff so that they don't panic when they come across with something they don't know so that they can learn...” (M15: 22 years).

5.4 SUMMARY OF CHAPTER

The study presented the findings of the study by first describing the demographic information of the midwives, gynaecologists and WWDs who participated in the study. Then the findings were presented as themes on focus group discussions with midwives and interviews with gynaecologists and lastly, interviews with WWDs. The next chapter discusses the findings in detail.

CHAPTER 6: DISCUSSION OF RESULTS

6.1 INTRODUCTION

This chapter discusses and interprets the results that were presented in Chapter 5. The findings are interpreted to develop categories (Gale *et al.* (2013: 5). Framework synthesis is conducted by “exploring the relationship between the main concepts, established literature and the theoretical perspectives” relating to barriers and facilitators of access to maternal healthcare services for WWDs (Smith and Firth 2011: 59). Carrol *et al.* (2013: 1) “stipulate that framework synthesis begins by creating a framework of priori themes and data from other studies against that framework”.

The discussion is organised into three sections. The first section is the presentation and discussion of the demographic profile of participants. The participants include midwives, gynaecologists who have provided maternal healthcare services to pregnant WWDs and WWDs who have accessed maternal health services from public health facilities. The second section discusses the results or sub-themes as themes, which are presented in Table 5.4 in Chapter 5. These themes are (a) access to maternal healthcare services, (b) inhibitors of access to maternal healthcare services for WWDs, and (c) facilitators of access to maternal healthcare services. They are discussed in relation to the conceptual framework for assessing access to healthcare services (Peters *et al.* 2008: 162). The last section discusses the results in relation to the objectives of the study and the new literature found as a result of themes that emerged through thematic synthesis.

6.2 Demographic profile of healthcare workers who provide maternal healthcare services for WWDs

The study included maternal healthcare services providers who had provided maternal healthcare services to WWDs in the previous year and were working in public healthcare facilities in KZN. These maternal health service providers

include 16 midwives, four gynaecologists and one medical officer. The study participants also included WWDs who had been pregnant in the previous five years. The WWDs would have accessed maternal healthcare services at a public healthcare facility. The participants in this study included four women with hearing impairments, four women with physical impairments and four women with visual impairments. Amongst the four women with physical impairments, one had both physical and visual impairments. Amongst the four women with visual impairments, one also had albinism. All the participants were willing to participate in the study. The demographic profiles of the maternal healthcare providers and WWDs are presented below.

6.2.1 Demographic profile of midwives

All the midwives who participated in this study were females. This is consistent with several studies conducted in different countries that had most of the midwives who participated as females. A study conducted in Slovenia had 98% of the midwives who participated in the study as females, a study in Nigeria had 100% of the midwives who participated as females and lastly, a study conducted in Yemen also had 100% of the midwives who participated as females (Mivšek *et al.* 2021; Kolade *et al.* 2014; Hyzam *et al.* 2020). In South Africa, a study in Limpopo had 94% females, and the other one in Gauteng had 100% females and lastly the one conducted in KwaZulu-Natal had 72.7% of newly graduated midwives as females (Ramavhoya *et al.* 2021, Hastings-Tolsma *et al.* 2021; Ngcobo, Baloyi and Javis 2021). The high percentage of female midwives may be due to the formalisation of stereotypical views held in most cultures that nursing and midwifery are professions for females (Berkery, Tiernan and Marley 2014: 708). According to McLaughlin *et al.* 2010: 306), “the nursing profession fulfils the feminine stereotypical image of nurturing, caring and gentleness in contrast to masculine characteristics of strength, aggression and dominance”.

6.2.2 Demographic profile of gynaecologists

The health workers who provide gynaecological services also included four gynaecologists and one medical officer. This is in line with the study on obstetric medical care in South Africa which found out that in secondary hospitals, specialists obstetricians provide obstetric services including medical officers with an interest in obstetric care (Wium, Vannevel and Bothma 2019: 28). The medical officer and the other two gynaecologists were males while two of the gynaecologists were females. The researcher also noted that although the retirement age is 65, most of the gynaecologists were between the ages of 20 and 40 and only one was between 40 and 60. This may be attributed to the fact that most senior and experienced gynaecologists had their own private practices where they worked (Ashmore and Gilson 2015: 5).

6.2.3 Demographic profile of WWDs

A total of 12 WWDs participated in the study. Of these 12 women, four had physical impairments and one had both physical and visual impairments. The participants also included four women with hearing impairments and four women with visual impairments. Amongst the four women with visual impairments, one woman also had albinism. The women were aged from 18 to 45 years. Six were aged between 28 and 38 years, four between 38 and 48 years and two between 18 and 28 years. All the women were African and not employed. Amongst the women, four were married while the other eight were single. In terms of education, one did not have any formal education, one had primary education, six had secondary education and four had tertiary education. These findings are in line with other studies conducted in South Africa, which found out that WWDs are most likely to be poor and not employed (Van der Heijden, Abrahams and Harries 2019; Lindsay, 2011; Hartley *et al.* 2011). The fact that of the 12 women, only four were married and eight were single is in line with the study by Van der Heijden, Abrams and Harries (2019: 831) that found that most WWDs had difficulties in forming life-long relationships.

6.3 Conceptualisation of access to maternal healthcare services

Peters *et al.* (2008) provide an in-depth description of the term access to healthcare in developing countries. In their framework, they describe access in terms of four main dimensions which are; geographical or physical accessibility, availability, financial accessibility and acceptability. The quality of healthcare services is central to all four dimensions. This study found that these dimensions can be categorised into systemic, structural and personal factors.

6.3.1 Systemic factors

Maternal health services as a system should cater for the needs of WWDs. The systemic factors alluded to by the participants included a) availability of human resources, b) knowledge and competency to handle WWDs, c) information and communication needs for WWDs, d) availability of information on the management of pregnant WWDs, e) referral system for WWDs, f) health financing, and g) multidisciplinary team.

6.3.1.1 Availability of human resources

Most of the healthcare workers described access to maternal healthcare services as dependent on the availability of human resources. According to the conceptual framework of assessing access to healthcare services, the dimension availability also entails; "... having the appropriate service providers..." (Peters *et al.* 2008: 162). Dubey *et al.* (2021: 140) further define availability as, "the sufficient supply of human resources corresponding to the health needs of the population". This study found out that not all levels of care have sufficient and appropriate service providers. In this study, the researcher noted that community healthcare centres did not have residential doctors or gynaecologists. There were also no gynaecologists in district hospitals, instead, maternal services were provided by midwives and medical officers. This is in line with a study by Thwala, Blaauw and Sengooba (2018: 7) which found out that there were no doctors working full time at community healthcare centres. Such uneven distribution of human resources across levels of care hinders

access to healthcare services Levesque *et al.* (2013: 9). The majority of the health workers indicated that the provision of services for WWDs requires more health workers compared to the provision of services for women without disabilities. The study however had mixed opinions in terms of the availability and adequacy of healthcare workers. The health workers from primary and secondary levels of care reported inadequate availability of healthcare workers while the tertiary levels of care reported adequate healthcare workers. This finding is consistent with other findings from studies conducted in other low- and middle-income countries where resources are disproportionately allocated with the tertiary levels care getting more resources compared to other levels (Devkota *et al.* 2018: 20).

6.3.1.2 Knowledge and competency to handle WWDs

The majority of WWDs revealed that some healthcare workers are not adequately equipped with the knowledge and skills to handle WWDs. Where health workers have adequate knowledge and are competent, then the facilities have appropriate healthcare workers to handle the population requiring services. As mentioned above, the conceptual framework for assessing access to health services emphasises that the facilities should have appropriate health workers who have adequate knowledge, skills and competency (Peters *et al.* 2008: 162). In this study, the workers felt that information on how to handle pregnant WWDs should be incorporated in the training curriculum and in some forms of in-service training. This finding is consistently reported in some low- and middle-income countries which also found out that the training curriculum as well as the in-service training was not inclusive of how to handle pregnant WWDs (Ganle *et al.* 2016; Nguyen 2016; Morrison *et al.* 2014). However, some of the WWDs indicated that the healthcare workers treated them well and did not feel that they lacked knowledge or were incompetent to handle them. The mixed opinions are consistent with a study done in India where there were mixed opinions amongst the WWDs regarding the knowledge and competency of health workers providing maternal services (Devkota *et al.* 2018: 19).

6.3.1.3 Information and communication needs for WWDs

Access for women with hearing and visual impairments was related to the issues of information and communication. Although Peters *et al.* (2008: 162) do not include information and communication in their conceptual framework, Thiede and McIntyre (2008:)) emphasise that in terms of access,))information and communication cut across all the dimensions of access. This study found out that communication between the healthcare workers and the people with hearing impairments was a problem in the absence of an interpreter. The absence of interpreters in maternal healthcare services was also reported in a study conducted in the Western Cape, South Africa and other low- and middle-income countries (Gichane *et al.* 2017, Kritzinger *et al.* 2014, Arulogun *et al.*; lezzoni *et al.* 2004). The women with visual impairments indicated that they have challenges in the information that is in an inaccessible format, for example, the antenatal classes have posters that are visuals, and all the notes are not in the braille format. This finding is in line with a study conducted in Ghana (Badu *et al.* 2019), Tanzania (Saulo, Walakia and Darj 2012) and Senegal (Burkke *et al.* 2017) where the women with visual impairments reported information, which is not in accessible formats. Furthermore, most midwives indicated that there is no information that is provided on the interaction of pregnancy and disability thus making them not confident to provide services to women with physical impairments. The paucity of information regarding pregnancy and WWDs was also reported in other studies in low- and middle-income countries (Ganle *et al.* 2017; Nguyen 2016).

6.3.1.4 Referral system for WWDs

The participants in the study revealed that access to maternal health services is related to the referral system of pregnant WWDs. This can be attributed to the fact that pregnant women with physical disabilities are regarded as high risk, therefore, require services from higher levels of care. The fact that WWDs are regarded as high risk and therefore must be referred to high levels of care is also articulated in other studies (Badu *et al.* 2019; Ganle *et al.* 2017). The referral from different levels of care relates to the geographical accessibility of

the conceptual framework for assessing access to healthcare. Geographical access refers to the physical distance between the maternal healthcare facility and WWDs or the time they take to travel to and from the facility seeking maternal health services (Peters *et al.* 2008: 162). In this study, some pregnant WWDs were referred to higher levels of care due to their pregnancy even if they were not ill. Consequently, they had to get their own transport to the higher levels of care. This is an additional burden to WWDs in terms of transport costs. Even though the facilities are accessible with public transport, in some areas, the WWDs have difficulties in accessing public transport as it is found a bit far from their homes. In their study which examined access to sexual reproductive health services for people with disabilities, Mavuso and Maharaj (2015: 15) also found out that the referral of WWDs to higher levels of care increases the distance between the WWDs and the facility where they have to access the services from. Another challenge noted was the unavailability of ambulances all the time. In this study, healthcare workers highlighted that there were some delays in transfers due to delays in ambulances. If there are delays during the transfer of pregnant WWDs, the outcomes may be fatal Mavuso and Maharaj (2015: 15).

6.3.1.5 Health financing

Health financing is another factor that was identified as an important aspect of access. It is related to the financial aspect of the conceptual framework for assessing access to healthcare services. Financial accessibility relates to the cost of the services in relation to the ability of the WDDs to pay for the services. This also entails the financial protection of the vulnerable population (Peters *et al.* 2008 162). In this study, the participants appreciated the fact that public maternal healthcare services, as well as other healthcare services for people with disabilities, are free of charge. As a result, WWDs do not experience out of pocket expenses. This finding is in contrast with the findings from Uganda, Cameroon and India which found out that the high cost of services hindered access to maternal healthcare services (Ahumuza *et al.* 2014; Bremer, Cockburn and Ruth 2010; Dean *et al.* 2017). Even though maternal healthcare

services were free for WWDs, this study also found that the WWDs had to incur additional costs in terms of transport as they had to be referred to higher levels of care and also had to access services from other specialities in different facilities from the maternal healthcare facility.

6.3.1.6 Multidisciplinary approach

The study also found out that access to maternal healthcare services for WWDs was related to a multidisciplinary approach. The multidisciplinary approach is related to the quality dimension of the conceptual framework of assessing access to healthcare services as it focuses on “composition, knowledge, competency and the skills mix of healthcare workers” (Dubey 2021: 140). A multidisciplinary approach was emphasised as a need to ensure a comprehensive provision of maternal services for WWDs. Different specialists such as neurosurgeons, social workers, occupational therapists and orthopaedic doctors, depending on the conditions, need to work together with the midwives and gynaecologists in order to ensure a successful pregnancy and delivery for WWDs (Smeltzer *et al.* 2016: 786). Very few studies have emphasised the need for a multi-disciplinary approach, and these few are from high-income countries (Lawler *et al.* 2013; Smeltzer *et al.* 2016; Konig-Bachmann, Zenzmaier and Schildberger 2019).

6.3.2 Structural factors

Structural factors were identified as some of the leading factors that impact access to maternal healthcare services for WWDs. These include a) infrastructural design and layout, b) examination beds, c) scales, and d) sanitary facilities.

6.3.2.1 Infrastructural design and layout

For pregnant WWDs to access maternal healthcare services with relative ease, the infrastructure should be designed to cater for their needs. Even though the conceptual framework for assessing access to healthcare does not emphasise

the aspect of accessibility of the infrastructure of healthcare facilities, Exworthy, Wilson and Forester (2011: 201) explain that the quality dimension of access also emphasises that the environment should be appropriate. This environment means minimal standards of accommodation and sanitation. This study found out that much needs to be done to transform maternal health institutions to make them disability friendly. The facilities had narrow passageways which women with physical visual impairments found difficult to navigate, and the ramps were absent at some facilities. The elevators in some facilities did not work and the situation was exacerbated by load shedding. These findings are in line with the findings of the study conducted in Durban by Mavuso and Maharaj (2015) and other studies in low- and middle-income countries (Nguyen *et al.* 2016; Tefera *et al.* 2017; Smith 2004) which outline that most maternal health facilities are not designed to suit the needs of WWDs.

6.3.2.2 Examination beds

According to the quality dimension of access, the medical equipment should be of a suitable standard and appropriate for the users (Peters *et al.* 2008: 162). Women with physical disabilities have challenges in getting on to high examination beds. The study found out the primary and secondary levels of care mainly had examination beds that were not adjustable. Such beds are not only a challenge for WWDs but also for healthcare workers who are short. Only the tertiary level of care had adjustable beds. The WWDs do not feel good when they have to be carried onto and off the beds and it becomes laborious for the healthcare workers. WWDs must bring relatives to assist the healthcare workers to carry them from wheelchairs onto the beds. Bremer, Cockburn and Ruth (2010) and Mitra *et al.* (2016) also report that maternal healthcare facilities did not have adjustable beds which led to women needing assistance to be put onto fixed high beds.

6.3.2.3 Disability-friendly scales

As outlined in the paragraph above, the quality dimension relates to the provision of appropriate and suitable medical equipment (Exworthy, Wilson and Forester 2011: 201). This study's findings reflected that disability-friendly scales are important during pregnancy for pregnant WWDs. However, in all the facilities from primary to tertiary institutions, none of them had disability-friendly scales. The healthcare workers indicated that this was a challenge for them as they need to monitor the weight of the pregnant women. As a result, WWDs do not get similar services to women without disabilities. This finding is in line with Bremer, Cockburn and Ruth (2010); Ahumuza *et al.* (2014) and Mitra *et al.* 2016, who reported that WWDs were not weighed during their pregnancy due to lack of suitable scales.

6.3.2.4 Sanitary facilities

The other quality dimension related issue that impacts access is the provision of appropriate sanitary facilities (Exworthy, Wilson and Forester 2011: 201). This study found out that in order to improve access to maternal services for WWDs, sanitary facilities should be designed in a manner that is disability friendly. Toilets and bathrooms should have wide doors and rails which WWDs can hold onto. However, this study found out that at the primary level of care and at the district level, the facilities did not have rails for WWDs to hold onto and the doors were not wide enough to allow wheelchairs to pass through. Sanitary facilities that are not disability friendly were also reported in studies from other low- and middle-income countries (Morrison *et al.* 2014; Ahumuza *et al.* 2014; Ledger *et al.* 2016; Rugoho and Maphosa 2017). In this study, WWDs and healthcare workers reported that access to maternal services was hindered by the provision of sanitary facilities that were not suitable for WWDs.

6.3.3 Personal factors

In addition to perceiving access in relation to the systemic issues, the participants in this study conceptualised access in relation to personal factors.

These factors include a) ability to read and write, b) availability of a companion, c) interaction of disability and pregnancy, d) own experience with a person with a disability, and e) healthcare worker attitudes toward WWDs and WWDs attitudes towards healthcare workers.

6.3.3.1 Ability to read and write

The study findings revealed that the ability to read and write amongst the women with hearing impairments was a major contributing factor to access. However, a study by Gichane *et al.* (2017: 438) noted that sign language has a different structure that is not aligned to the syntax of other languages which makes learning to read and write in other languages a challenge for women with hearing impairments. Furthermore, deaf women in South Africa on average read at the level of fourth grade which makes it difficult for them to understand medical terms (Glaser and Lorenzo 2006). In addition, the Human Rights Charter stipulates that healthcare workers must inform the users using the language that they understand, considering their literacy levels (Harichan, Heap and London 2013: 59). Not communicating with the healthcare users in the language that they understand can be considered a violation of human rights. Furthermore, written communication cannot be used during labour so even for those who can read and write, there is no clear communication during labour (Gichane *et al.* 2017: 438).

6.3.3.2 Availability of a companion

The participants in the study alluded to the fact that access for WWDs was related to the availability of a companion which is a factor not included in the conceptual framework for assessing access to healthcare. This study revealed that for WWDs, the availability of a companion is an important factor that impacts access. A companion would assist with interpreting sign language for the women with hearing impairments, guiding the women with visual impairments navigating the facility and assisting the healthcare workers with the lifting of the WWDs to and from the examination beds. Having a companion who would assist in interpreting for the women with hearing impairments, helps

in guiding the women with visual impairments and assisting the women with physical impairments to navigate the facility. Other studies, Mitchell *et al.* (2021), Gichane *et al.* (2017), Smeltzer *et al.* (2016) and Ahumuza *et al.* (2014), also reported that a companion assists in interpreting for women with hearing impairments and guiding women with visual impairments and assisting women with physical impairments to navigate the facility. However, having to take a companion was an additional cost to the already impoverished WWDs.

6.3.3.3 Interaction between impairment and pregnancy

The study found out that some impairments interacted with a pregnancy resulting in some complications which are challenging in terms of provision of care. With such complications, some will need to be hospitalised for a long period of time before and after their delivery. Such complications may require extra care and more healthcare workers as compared to care provided to women without disabilities (Mitra *et al.* 2015). Unfortunately, WWDs felt that even when they were feeling well, they would be regarded as high risk and referred to higher levels of care. This would make them travel far from their locality to the referral facilities. The midwives also attested to the fact that if they feel that there is a likelihood of a complication, they refer. This finding is in line with Smeltzer *et al.* (2016: 785) who reported that WWDs felt that they are regarded as higher risk and needed extra care, which is offered at higher levels of care.

6.3.3.4 Own experience with a person with a disability

The other finding from this study was that healthcare workers who had relatives with disabilities believed that they understood how to provide services to WWDs. Their experience at home equipped them with the confidence and skills to handle WWDs. This finding is in line with other studies that found out that although some healthcare workers were not trained in handling pregnant WWDs, “they displayed positive attitudes towards WWDs because they had relatives with disabilities” (McKay, Moffat and Cunningham, 2006; Walsh-Gallagher, Sinclair and McConkey, 2013).

6.3.3.5 Length of provision of service

Length of provision of service was also found out to relate to access to maternal health services for WWDs. Health workers who had more experience in the provision of maternal health services felt that they had better understanding of WWDs and skills to assist them. Their years of services had exposed them to several WWDs needing different kinds of care which prepared them to attend to WWDs. This is referred to as action competence whereby one is able to react adequately to deviations from the norm and develop strategies to address the situation (König-Bachmann, Zenzmaier and Shildberger 2019). However, König-Bachmann, Zenzmaier and Shilberger (2019) also acknowledge that the action competence on the provision of maternal healthcare services is restricted due to the limited number of WWDs that they attend to.

6.3.3.6 Attitudes of healthcare workers towards WWDs and attitudes of WWDs towards healthcare workers

The study revealed that that the topic of pregnant WWDs was a challenge to some of the healthcare workers and this influenced how they handled the women. The interviews gave the healthcare workers an opportunity to reflect and recognise their own prejudices and ideas regarding pregnancy and delivery of WWDs. König-Bachmann, Zenzmaier and Shilberger (2019: 560) noted that the prejudices of healthcare professionals have an impact on the quality of the service which can result in oppression, isolation and marginalisation of WWDs. Some of the healthcare workers emphasised the impairment rather than looking at the available options and possibilities. The WWDs reported that healthcare workers verbally and acted in ways that indicated that they did not expect WWDs to become pregnant. Several other studies found similar results of healthcare workers depicting negative attitudes towards WWDs (Devkota *et al.* 2017; Ganle *et al.* 2017; Ahumuza *et al.* 2014). This study also found out that midwives felt some pregnant women had negative attitudes towards being examined by midwives. This may be because pregnant WWDs have been seen as high risk and normally have to receive care from gynaecologists. This has led them to think that midwives are not competent enough to handle them.

6.3.3.7 Empowerment of WWDs

WWDs are a vulnerable population who sometimes decide to keep quiet rather than raise their concerns (Gichane *et al.* 2017: 436). This study found out that WWDs who were able to speak up and raise their concerns were able to get the service they wanted and were most likely to report that they received good quality of care. This can be attributed to the fact that the healthcare workers have inadequate skills and experience to handle WWDs and where a woman with a disability is able to express her concerns and state specifically what they want, the healthcare workers will be confident to provide that care knowing that it is what the woman needs. The WWDs, therefore, need to be considered as experts, not a vulnerable population as their input would help to ensure access to health services is realised (Lawler 2010: 214).

6.4 INHIBITORS OF ACCESS TO MATERNAL HEALTHCARE SERVICES FOR WWDs

The main categories found in the present study include a) infrastructural design, b) lack of information on handling pregnant WWDs, c) health worker acceptance, d) cost of services, and e) communication.

6.4.1 Infrastructural design

According to the findings of this study, the infrastructure was not designed to suit the needs of WWDs. Inaccessible infrastructure is a violation of Section 27 of the South African Constitution, which provides that everyone has the right to have access to health services including reproductive health services. The inaccessible infrastructure discourages WWDs from seeking services. In addition, the quality dimension of access speaks to the provision of appropriate and suitable infrastructure (Exworthy, Wilson and Forrester 2011: 162). Therefore, facilities that do have appropriate infrastructure for WWDs are providing poor quality services to the WWDs. The main categories were internal arrangements and space availability and lack of accessible equipment.

6.4.1.1 Internal arrangements and space availability

The study found out that that the facilities have narrow passages are and without proper signage. Some institutions have stairs and do not have ramps and the consultation rooms are very small such that the wheelchairs cannot fit in. Barriers to the built environment which include lack of ramps in driveways, narrow passages and doorways and facilities having stairs were also reported in other studies from low- and middle-income countries (Devkota *et al.* 2018; Ganle *et al.* 2016; Ahumuza *et al.* 2014). The inaccessibility of the built environment was also reported in studies from high-income countries (Lawler 2010; Mitra *et al.* 2016; König-Bachmann, Zenzmaier and Shildberger 2019), where lack of ramps, narrow doorways were hindering access for WWDs were reported.

6.4.1.2 Lack of accessible equipment and devices

This study also found out that over and above inaccessible infrastructure, the equipment and devices that are in the maternity wards are not disability friendly. Studies from both low- and middle-income countries and high-income countries have consistently reported lack of accessible equipment and devices in maternal healthcare centres (Smith *et al.* 2004; Morrisson *et al.* 2014; Ahumuza *et al.* 2014; Mitra *et al.* 2016; König-Bachmann, Zenzmaier and Shildberger, 2019). Lack of accessible equipment and devices leads to more work for the healthcare workers as they must assist the WWDs to get onto the high fixed beds which the WWDs could have easily done by themselves had the beds been adjustable. The WWDs feel embarrassed and degraded as they appear not capable of certain activities yet if there is accessible equipment, they will be capable.

6.4.2 Lack of information on how to handle pregnant WWDs

This study found that there was lack of information on how to handle WWDs amongst the healthcare workers. The categories include lack of understanding

of the needs of the WWDs, lack of training amongst healthcare workers, assumptions of risk, and stigmatisation and marginalisation.

6.4.2.1 Lack of understanding of the needs of WWDs

This study revealed that maternal health service providers did not adequately understand the needs of WWDs. This is mainly due to the fact that there are no adequate practice guidelines for healthcare workers to follow when providing services for WWDs. Lack of understanding leads to fear and insecurity amongst the healthcare workers. The fear and insecurity may lead to suboptimal care provided to WWDs. This finding is consistent with other studies (Trani *et al.* 2011; Ahumuza *et al.* 2014; Devkota *et al.* 2017).

6.4.2.2 Lack of training on how to handle pregnant WWDs

The lack of information is exacerbated by the fact that the training curriculum does not adequately prepare healthcare workers to be able to handle pregnant WWDs. The curriculum does not have specificity regarding WWDs resulting in some healthcare workers treating the WWDs as women without disabilities. Healthcare workers recommended the pre-service training curriculum and in-service training to include the handling of pregnant WWDs. This finding is in line with findings from other studies (Ahumuza *et al.* 2014; Ganle *et al.* 2016).

6.4.2.3 Assumptions that WWDs are high-risk patients

The lack of adequate information to handle WWDs led to the healthcare workers assuming that all WWDs are high risk. This finding is in line with other studies (Smith *et al.* 2004; Ganle *et al.* 2016). This results in WWDs being referred to higher levels of care when they could easily be helped in the lower levels of care which are in most of the cases closer to their localities. With adequate information, healthcare workers could easily identify those that are high risk and those that are low risk. The referral will be done only for those who really need care. There is a body of literature indicating that WWDs are high risk, however, there is no specific detail of which form of disability and what

the risk is (Mitra *et al.* 2016; Smeltzer *et al.* 2016). The assumption that all WWDs are high risk has led to some healthcare workers discouraging the WWDs from getting pregnant. This is a violation of the human rights of WWDs as they have a right to access sexual reproductive health services and have a right to choose whether to have children or not.

6.4.2.4 Marginalisation and stigmatisation

Generally, WWDs are a marginalised population. They reported that they were marginalised and stigmatised by the healthcare workers. The marginalisation may be due to the healthcare workers lacking knowledge on how to handle pregnant WWDs or it may be due to the dominant belief that the WWDs are asexual and therefore should not get pregnant and have children. This study is in line with other studies that recorded that WWDs experienced stereotyping and stigma when they visited the healthcare facilities (Smeltzer *et al.* 2016: 787). The WWDs did not welcome the stereotypical views or the stigma that was expressed by the healthcare workers. However, because the healthcare workers have power and authority, the WWDs did not raise their concerns and suffered silently. Some of the healthcare workers reflected on their interactions with WWDs where they noted that WWDs feel bad because healthcare workers cannot explain the procedures or what is happening to them during labour. Other studies also reveal that health workers are insensitive to the needs of the WWDs (Devkota *et al.* 2018; Ganle *et al.* 2016; Morrison *et al.* 2014, Bremer, Cockburn and Ruth 2010).

6.4.3 Healthcare worker acceptance

According to the conceptual framework for assessing access to healthcare, the acceptability of health services is the ability of services to meet the cultural and the ethical expectations of healthcare users including individual care (Peters *et al.* 2008: 162). Acceptability of health services can also be seen in interactions between healthcare workers and WWDs. The categories that emerged include a) staff attitudes towards WWDs, b) attitudes of WWDs towards midwives, and c) quality of maternal healthcare services.

6.4.3.1 Staff attitudes towards pregnant WWDs

Women with disabilities expressed that healthcare workers demonstrated negative attitudes towards them and their pregnancy. Some of the WWDs reported being treated with disrespect by healthcare workers. The WWDs noted that not all healthcare workers were disrespectful. The disrespect was displayed in form of yelling and ignoring the calls by WWDs. Such kinds of abuse have also been documented amongst studies for women without disabilities (Kruger and Schoombee 2009: 89). Such abuse dissuades WWDs from visiting the health facilities early. Although disrespectful treatment has been recorded in studies for women without disabilities, it is important to note that disability worsens the situation. The negative attitudes may be due to lack of training and knowledge amongst the healthcare workers as well as assumptions on what WWDs can and cannot do. These findings are consistent with other studies conducted in South Africa (Adigun and Mngomezulu, 2020; Gichane *et al.* 2017; Mavuso and Maharaj, 2015) as well as other parts of the world (Mitra *et al.* 2019; Sheildberger, Zenzmaier and König-Bachmann, 2017). These studies report that the social beliefs of healthcare workers, which perceive WWDs as asexual and are not capable of mothering babies lead to WWDs feeling disrespected.

6.4.3.2 Attitudes of WWDs towards midwives

In this study, some healthcare workers particularly midwives, indicated that there were some women with physical disabilities who expressed that they were not interested in being examined by midwives. They preferred to be examined by gynaecologists. This may be because women with physical disabilities have been considered to be high risk and mostly referred to high care, therefore, the WWDs believe that only gynaecologists are able to handle them. The midwives indicated they do not attend to such WWDs because of the attitude of these WWDs yet because of their profession they are expected to. The midwives felt their skills and knowledge were being undermined by the WWDs. To the best of the researcher's knowledge, no research has ever explored this aspect.

6.4.3.3 Quality of maternal health services

Even though the healthcare workers strived to provide good quality maternal healthcare services, most of them perceived the quality of the service they provided to the WWDs to be poor. Some of the WWDs also raised concerns about receiving poor quality service. Poor quality of services was ascribed to lack of accessible infrastructure and equipment, negative attitudes of health workers, lack of knowledge and skills to handle WWDs and inadequate human resources especially in primary and secondary levels of care. Poor quality of maternal healthcare services has been recorded in studies that included the general population (Jewkes, Abrahams and Mvo, 1998; Tlebere *et al.* 2007). The situation of WWDs is worsened by the fact they also need services that are suited to their specific impairments. These findings are consistent with findings from other studies which also found that the quality of services provided to WWDs is poor due to inadequate human resources and inappropriate infrastructure (Trani *et al.* 2011, Gichane *et al.* 2017; Adigun and Mngomezulu, 2020). Poor quality of maternal services will dissuade WWDs from presenting for maternal healthcare services early.

6.4.4 Cost of services

One of the dimensions of access according to the conceptual framework for assessing access to healthcare is financial accessibility, which means maternal healthcare services should be financially affordable to WWDs (Peters *et al.* 2008: 162). In South Africa, healthcare for people with disabilities, pregnant mothers and children under five is for free. Even though maternal services are for free, the study found out that WWDs incurred other expenses in the process of seeking free health services. The categories included a) additional expenses to access maternal healthcare services and b) transport costs.

6.4.4.1 Additional expenses to access maternal healthcare services

One of the points raised in the study was that the WWDs had to be escorted to the health facilities. The escorts were to assist the WWDs with navigating the

health facilities, providing interpreting services and assisting with carrying the babies in the case of post-natal care. Even the healthcare workers expected that the WWDs should always bring someone and when they did not, they were shouted at. Having an escort becomes as if it is mandatory due to the fact that the facilities are not suited for the needs of WWDs. Additional help would be needed from family members or friends to ensure that the WWDs access the needed services. Having an escort means additional costs in terms of transport. These findings are consistent with those from other studies which reported that WWDs would require friends or family members to escort them to the health facility (Ganle *et al.* 2017; Ahumuza *et al.* 2014; Morrison *et al.* 2014).

6.4.4.2 Transport costs

The study findings revealed that most of the WWDs are not employed. However, these WWDs are regarded as high risk and hence are referred to higher levels of care. In most instances, their referrals happen when they are not emergency cases and hence, they are required to transport themselves to the higher levels of care that are not within their locality. This increases the distance travelled from home to seek health services which in turn increases the transport cost. The transport cost is worsened by the fact that the WWDs would need to be accompanied by a family member or partner to the facility. This makes the transport costs more expensive than what it is for pregnant women without disabilities. Other studies also reported that WWDs incur additional transport costs as they have to be accompanied and are also referred to higher levels of care (Ahumuza *et al.* 2014; Ganle *et al.* 2017; Adigun and Mngomezulu, 2020).

6.4.5 Communication challenges

Communication is an important aspect to ensure that access is realised (Thiede and McIntyre 2008: 5). This study revealed a great challenge in terms of communication between women with hearing impairments and healthcare workers. A few healthcare workers also noted a challenge of communication between the healthcare workers and the women with visual impairments. The

main categories that were raised are a) lack of training in sign language, b) lack of sign language interpreters and c) lack of assistive communicative devices.

6.4.5.1 Lack of training on sign language

Both healthcare workers and the women with hearing impairments raised a concern that the maternal healthcare workers could neither understand nor communicate appropriately using sign language. This is in line with other studies conducted in other countries (Peta 2017; Ganle *et al.* 2017). Even though the South African Department of Health emphasises the importance of training all front-line healthcare workers in sign language, most healthcare workers in this study indicated that they had not received sign language training yet a few of them indicated that they had minimal training which did not give them adequate skills. This finding is in contrast with Dlamini and Sibiya (2020; 16) who found out that most healthcare workers reported that they had received minimal training in sign language, and a few had reported that they had not received sign language training. Even though communication is one of the most important tools in the health worker profession, sign language is not incorporated in the pre-service training curriculum of healthcare workers (Machado *et al.* 2013: 290).

6.4.5.2 Lack of sign language interpreters

Sign language interpreters are important in ensuring that communication between healthcare workers and women with hearing impairment can interact effectively. The study found out that the facilities did not have sign language interpreters. The lack of sign language interpreters led to women with hearing impairments relying on their relatives to interpret their sign language for the healthcare workers. Some of the healthcare workers raised a concern that this could lead to a breach of confidentiality as the women with hearing impairments would have to inform the relative of certain conditions that they would rather explain to the healthcare worker only. The lack of sign language interpreters and the issue of relying on relatives to be interpreters is also reported in other studies (Gichane *et al.* 2017; Devkota *et al.* 2018). Fear of failure to

communicate led some healthcare workers to refer women with hearing impairments to higher levels of care. The lack of effective interaction between women with hearing impairments and the healthcare workers may result in adverse outcomes which could be avoided (Mitra *et al.* 2016: 5).

6.4.5.3 Lack of assistive communicative devices

Assistive communicative devices would improve the communication between healthcare workers and women with hearing and visual impairments. However, the study found out that the primary and secondary health facilities do not have some of the basic assistive devices. This may be a result of the biomedical model of disability which focuses on dealing with the disability rather than improving the social and physical environment to ensure that it eliminates the disabling factors (Goering 2015: 134). The lack of assistive communicative devices results in women not being able to communicate with the healthcare workers. Healthcare workers indicated that having beds with bells and flashlights would ensure that the WWDs will manage to call for the attention of healthcare workers with relative ease. Most studies focus on the lack of training and interpreters but rarely refer to assistive communicative devices (Gichane *et al.* 2017 and Ganle *et al.* 2017).

6.5 THEME 3: FACILITATORS OF ACCESS TO MATERNAL HEALTHCARE SERVICES

Despite the numerous barriers to access maternal health for women, the study also revealed some factors that can enhance access to maternal healthcare services. The facilitators of access allude more to the bio-social model of disability which challenges healthcare to find ways for mainstreaming, accommodating and improving accessibility for the WWDs (Goering 2015: 136). The categories that emerged include a) support from friends and family, b) availability of resources, and c) own experience with people with disabilities.

6.5.1 Support from friends and family

Navigating the health facility is a challenge for WWDs. Due to shortages of healthcare personnel, the healthcare workers are not able to assist the WWDs with navigating around the facility. The category that emerged was the availability of a companion during hospital visits.

6.5.1.1 Availability of a companion during hospital visits

The study revealed that the availability of a companion during the health service visit was a facilitator of access to maternal health services. The companion would assist with sign language interpretation for women with visual impairments, navigating the facility for women with physical and visual impairments and carrying the women with physical impairments onto and off the high fixed beds. The findings are consistent with those from other studies which also found that family members assist with interpreting sign language and navigating the health facility (Gichane *et al.* 2017; Ganle *et al.* 2017; Mavuso and Mahaj 2015). However, a study by Gichane *et al.* (2017) found that the companion was only restricted to outpatient services and during visiting hours, and the women with hearing impairments would stay with no interpreter all the other time. This caused challenges in communication between healthcare workers and women with hearing impairments.

6.5.2 Availability of resources

Availability of resources is one of the important dimensions of the conceptual framework for assessing access to healthcare services (Peters *et al.* 2008: 162). In this study, the availability of resources was an important factor that enhanced access to maternal health services. Where appropriate and adequate resources are available good quality services are provided. The categories included a) availability of a team of maternal healthcare service providers at all times, b) availability of disability-friendly resources, and c) availability of a multidisciplinary team.

6.5.2.1 Availability of a team of maternal healthcare service providers at all times

The study found out that pregnant women require the support of more healthcare workers and more time as compared to the healthcare workers supporting women without disabilities. This is consistent with the finding that care for WWDs is frequently accompanied by an increase in workload due to preparatory research, potential communication barriers and specific measures (König-Bachmann *et al.* 2019: 5). This study found out that the WWDs received quality healthcare services at the tertiary institution, as there is always a team of maternal healthcare workers available. However, the primary and secondary levels of care did not have adequate healthcare workers thereby hindering the provision of quality health services. This finding is in line with a study by Thwala, Blaauw and Ssengooba (2018: 7) which revealed an inequitable distribution of skilled maternal service providers with some facilities having an oversupply and other facilities having an undersupply. Ensuring that adequate skilled maternal health services are available would enhance access to maternal health services not only for WWDs but also for women without disabilities.

6.5.2.2 Availability of disability-friendly equipment

Disability-friendly equipment helps WWDs to be able to navigate through the facility on their own. It included the availability of adjustable beds, wheelchairs and other assistive devices. In this study, the tertiary level facilities have adequate assistive devices and disability-friendly equipment. This finding is in contrast with a study by Jumare, Kanaya and Stieger (2013), which found out that there is an acute shortage of beds in all levels of maternal healthcare services in South Africa. Furthermore, other studies report a severe shortage of disability-friendly equipment (Ahumuza *et al.* 2014; Mitra *et al.* 2016 Ganle *et al.* 2017). The importance of the availability of disability-friendly equipment in enhancing access to maternal health services cannot be over-emphasised.

6.5.2.3 Availability of a multidisciplinary team

This study revealed the importance of the availability of a multi-disciplinary team in ensuring access to maternal healthcare services. Women with disabilities require the services of other healthcare service providers other than maternal care providers. Seeking services of the other providers from other facilities would increase the cost for seeking services and stress to the pregnant WWDs. Inter-professional cooperation is of great importance. The study found out that to ensure the quality of services and the safety of WWDs, the maternal health providers work together with other healthcare workers from other specialities. This is in line with a finding from a study in Austria, which found out that inter-professional cooperation resulted in adequate care provided to WWDs and it served as an instrument of quality assurance and facilitated networking with healthcare workers from other specialities (König-Bachmann *et al.* 2019: 5). This multi-disciplinary team was available and accessible at a tertiary facility. Some healthcare workers recommended that there be a facility that has a multidisciplinary team so that the WWDs will know that whenever they need any service there is an institution that has all the services for them.

6.5.3 Experience with people with disabilities

The study also found out that the healthcare workers who had experience with caring for people with disabilities displayed a better attitude and provided better care to pregnant WWDs. The categories that emerged were a) having a family member with a disability, and b) length of providing maternal healthcare services.

6.5.3.1 Having a family member with a disability

Healthcare workers who had relatives with disabilities felt better prepared to provide maternal healthcare services for WWDs. They had less anxiety and related well to the WWDs. The findings are in line with a study done in Zimbabwe by Peta, where a woman with hearing impairments explains that she was helped to deliver by a nurse who had two children who are deaf (Peta,

2017: 16). This finding indicates that a lack of knowledge and competence to handle WWDs impacts the competency of the healthcare workers. The healthcare workers who experience people with disabilities at home then transfer that competency when they are in the work environment. The lack of experience amongst the healthcare workers leads to the fear of making mistakes and violating the autonomy of WWDs; however, such fear must be turned into a powerful trusting relationship between the healthcare workers and the WWDs (König-Bachmann *et al.* 2019: 5).

6.5.3.2 Length of providing maternal healthcare services

The study found out that the longer a healthcare worker is in service, the greater the chances of one to have provided maternal services to WWDs. Having provided services to WWDs gives the healthcare workers the confidence that is needed to provide quality services to other WWDs. This study finding is in contrast with a study conducted in Nepal which found out that a more positive attitude was displayed amongst the young healthcare workers (Devkota *et al.* 2017). However, the study findings are in line with those from studies conducted in America and Europe which found out that positive attitudes were displayed by older healthcare workers with more experience in the provision of maternal healthcare (Walsh-Gallagher, Sinclair, and McConkey, 2013; Bremer, Cockburn and Ruth, 2010). To capitalise on the experienced healthcare workers, at the tertiary level, they pair the most experienced midwives with those who are newly qualified. This finding is consistent with a study where healthcare workers expressed their desire for platforms to exchange information on the care for WWDs (König-Bachmann *et al.* 2019: 5).

6.6 Results in relation to the objectives of the study

The aim of the study was to explore the factors that impact access to public maternal healthcare services for WWDs in KZN with the ultimate goal of developing a practice framework to improve WWDs' access to maternal healthcare services. The current study achieved these objectives by; a) describing the experiences of WWDs in accessing maternal healthcare

services during pregnancy, childbirth and postpartum care, b) describing the inhibitors of access to maternal healthcare service for WWDs, c) describing the facilitators of access to maternal healthcare services, and d) describing how access to maternal healthcare services can be improved.

The results in relation to the research questions asked in the study are discussed next.

- 1) What are the practices of maternal healthcare service providers in providing service to WWDs? Midwives, gynaecologists and medical officers described their experiences in providing maternal healthcare services to WWDs. The results indicated that the healthcare workers do not have proper training regarding the provision of maternal healthcare services and at times just provide services as if providing healthcare services to women without disabilities. The midwives and community healthcare centre referred anyone who had a physical disability to a higher level of care. At times the women with hearing impairments were referred to higher levels of care for fear of complications that may result during labour and delivery as a result of challenges in communication.
- 2) What are the perceptions of maternal healthcare service providers with regard to access to maternal healthcare services for WWDs? The healthcare workers perceived the maternal healthcare services for WWDs to be of poor quality due to shortages of human resources in primary and secondary health facilities, inaccessible infrastructure including sanitary facilities and lack of disability-friendly equipment and communication challenges.
- 3) What are the perceptions of WWDs with regard to access to maternal healthcare services? A few of the WWDs perceived the maternal healthcare services to be of good quality. The visually impaired raised the concern of narrow passages which are difficult to navigate and also information that is not accessible in braille. Women with hearing impairments raised concerns of challenges in communication and

negative attitudes, rudeness and being ignored when asking for help. Physically impaired women raised issues regarding inaccessible buildings, narrow passages and small consultation rooms as well as beds that are not adjustable.

- 4) What would improve access to maternal healthcare services for WWDs?
Both healthcare workers and WWDs recommended the training of healthcare workers in the use of South African Sign Language (SASL), health facilities to have sign language interpreters, renovating the physical infrastructure to make it disability-friendly, the pre-service curriculum and in-service to include information on how to handle pregnant WWDs.

6.7 SUMMARY OF CHAPTER

The chapter discussed the demographic profile of gynaecologists, midwives and WWDs. It also discussed and interpreted the results using the conceptual framework for accessing access to maternal healthcare services. The chapter also explored the barriers and facilitators of access to maternal healthcare services for WWDs. To the best of the current researcher's knowledge, this study is one of the few studies undertaken to understand how WWDs access maternal healthcare services looking at the different levels of care. Access to maternal healthcare services is important to reduce maternal mortality and to ensure that the rights of WWDs are realised. The study supported and contributed to a new understanding of how to enhance access to maternal healthcare services for WWDs. The next chapter describes the framework that can be adopted to enhance access to maternal healthcare services.

CHAPTER 7: FRAMEWORK FOR IMPROVING WOMEN WITH DISABILITIES' ACCESS TO MATERNAL HEALTHCARE SERVICES

7.1 INTRODUCTION

The purpose of the study was to explore the factors that impact access to public maternal healthcare services for WWDs in KZN with the ultimate goal of developing a practice framework for improving WWDs' access to maternal healthcare services. This chapter discusses the final stage of the qualitative research by identifying relationships between the themes identified in the study and the dimension of access in the conceptual framework for assessing access to healthcare services discussed in Chapter 3. A framework synthesis was utilised to summarise the themes that emanated from the study. The framework depicts the conceptualisation of access, the factors that enhance access and the factors that inhibit access to maternal healthcare services for WWDs. This chapter focuses on the conceptualisation of access and the factors that enhance access to maternal healthcare services for WWDs and links them to the dimensions of access in the conceptual framework for accessing healthcare services to develop a practice framework for improving WWDs' access to maternal healthcare services.

7.2 A FRAMEWORK FOR ASSESSING ACCESS TO MATERNAL HEALTHCARE SERVICES

The previous chapter discussed the findings of the current study. In all the information provided in the preceding chapters, the focus has been on the first three objectives of the study which 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.
- Explore the facilitators of access to maternal healthcare services for women with disabilities.

This section focused on the last objective of the study which is to describe how access to maternal healthcare services by WWDs can be improved. For the access to maternal healthcare services for WWDs to be improved, the WWDs' perinatal needs should be incorporated in every dimension of access. These dimensions include accessibility, availability, acceptability and quality (Peter *et al.* 2008: 162). In this study, the perinatal access needs of WWDs were identified through interviewing the WWDs and the maternal healthcare providers.

The conceptual framework discussed in Chapter 3 focused on assessing access to healthcare services in general, and the concepts in that framework were used when analysing and discussing the data of the current study. The study results indicated that there are barriers to access to maternal healthcare services for WWDs as well as areas that require improvement. The goal of the practice framework is to improve WWDs' access to maternal healthcare services.

7.3 A PRACTICE FRAMEWORK FOR IMPROVING WWDS' ACCESS TO MATERNAL HEALTHCARE SERVICE

Guided by the conceptual framework of assessing access to healthcare services (Peters *et al.* 2008: 162), the researcher developed a framework (Fig 7.1) for improving WWDs' access to maternal healthcare services. The framework explains access in four dimensions, which are accessibility, availability, acceptability and quality. It reflects on how the healthcare workers and WWDs conceptualised access and incorporates the factors that need to be improved in order to enhance WWDs' access to maternal healthcare services. The categories that emerged with regard to the conceptualisation of access

include systemic, structural and personal factors. The study further explored the factors that enhance access to maternal healthcare services for WWDs. These factors were identified in this study and corroborated in other studies (Mitra *et al.* 2015; Smeltzer *et al.* 2015). The next section describes the framework.



Figure 7.1: A practice framework for improving WWDs access to maternal healthcare services

7.3.1 Factors impacting women with disabilities' access to maternal healthcare services

The study revealed that there are several factors that impact WWDs' access to maternal healthcare services. These factors were categorised into three main categories which include a) systemic, b) structural and c) personal. All these

factors are interconnected and if they are enhanced, they result in good quality maternal healthcare services provided to WWDs.

7.3.1.1 Systemic factors

The healthcare systems must develop the capacity to include WWDs into the mainstream maternal healthcare services. This can be achieved by ensuring that maternal healthcare services have adequate and appropriate healthcare workers, adequate and appropriate information, and healthcare services are financially accessible.

a) Availability of adequate and appropriate healthcare workers

Provision of maternal healthcare services requires health workers who have adequate knowledge and skills to handle WWDs. Healthcare workers should be provided with training so that they are able to provide services that are responsive to the needs of WWDs (Apolot *et al.* 2019: 9). In addition, the healthcare workers should be in sufficient numbers as indicated by the WHO guidelines of emergency obstetric and neonatal care (EmNOC) facilities to ensure that WWDs receive the care when they need it for example at a CHC, there should be five advanced midwives and five midwives at any given time (Thwala, Blauw and Ssengooba 2018: 7).

b) Availability of adequate and appropriate information

To ensure that healthcare workers provide appropriate care to WWDs, healthcare workers should be provided with evidence-based guidelines on the provision of maternal healthcare services for WWDs and information regarding pregnancy and disability (WHO, 2011; Mitra *et al.* 2016; Nguyen *et al.* 2019). The guidelines will eliminate the anxiety and lack of confidence amongst the healthcare workers when confronted with pregnant WWDs. Furthermore, the health systems should provide training on interpersonal communication skills with WWDs to ensure healthcare workers are able to transfer information and understand WWDs including those with hearing impairments.

c) Health financing

Women with disabilities are disproportionately poor and are most likely to be single. Although WWDs are recipients of social grants, the extra costs they incur may be more than the grants that they receive. In addition, some of the WWDs do not receive the grants and they lack information that indicates that they are eligible and how they can access the grants. Pregnant WWDs could be provided with vouchers that they could use for transport services and any other additional costs they incur during pregnancy and delivery. The voucher system is used in other developing countries to ensure that pregnant women from disadvantaged communities access healthcare services (Devkota *et al.* 2018:15).

d) Referral System

Women with disabilities at times travel long distances to access services at higher levels of care. The health system could also include WWDs to be part of the outreach service so that they could receive health services closer to their homes. The outreach team should comprise adequately skilled maternal health providers (Apolot *et al.* 2019: 9).

e) Multidisciplinary approach

Since WWDs' pregnancy may interact with their impairments, there is a great need for inter-professional cooperation when providing healthcare service to pregnant WWDs. The healthcare system could provide a few facilities that have a team of healthcare professionals who work together where WWDs can access these services (König-Bachmann *et al.* 2019: 5). This team could also be available for outreach services to ensure that WWDs receive services closer to their homes.

7.3.1.2 Structural factors

Efforts to improve maternal healthcare access should also include improving the geographical accessibility of health facilities. Healthcare facilities should

have appropriate infrastructure and equipment (Mitra *et al.* 2016; Apolot *et al.* 2019).

a) Appropriate infrastructural design and layout

Facilities need to be modified to accommodate the needs of WWDs. Some modifications include ramps, widening the doors, spacious consultation rooms, wide passages, and sanitary facilities that have seats that can be used by WWDs, with rails that WWDs could hold onto (Ahumuza *et al.* 2014; Peta, 2017, Nguyen *et al.* 2019). The infrastructure designed to suit the needs of WWDs will enable WWDs to navigate the facilities with relative ease.

b) Appropriate equipment and devices

Infrastructure which is suitable for WWDs needs to be coupled with appropriate assistive devices for mobility, communication and climbing beds and seats (Ganle *et al.* 2016; Apolot *et al.* 2019). There is also a need to have adjustable beds and scales that can accommodate WWDs with physical impairments (Mitra *et al.* 2015). Such assistive devices will assist in maintaining WWDs' dignity as they can navigate the facility on their own or with little help.

7.3.1.3 Personal factors

Personal factors also impact access to maternal healthcare services. They could be amongst the WWDs or the healthcare workers. The personal factors include empowerment of WWDs, attitudes of healthcare workers and support from family and friends.

a) Empowerment of WWDs

As WWDs are mostly from disadvantaged backgrounds, they rarely complain and raise concerns regarding their treatment during pregnancy and delivery (Devkota *et al.* 2018: 16). Women with disabilities require empowerment in order to be able to speak out about their needs. This can be done by sensitising the citizens about the special needs of WWDs and decision-makers to listen

and incorporate the voices of the WWDs in policies and guidelines of provision of maternal health services for WWDs. Women with disabilities need to be put in strategic positions at different levels of maternal healthcare services so that they can bring change and address the self-stigma that affects the WWDs (Peta 2017: 16). This is due to the fact that WWDs are experts of their bodies and understand their bodies better than anyone else (Smeltzer *et al.* 2016: 786).

b) Attitudes of healthcare workers

Health systems need to sensitise the healthcare workers on the special needs of WWDs. The sensitisation should focus on interpersonal communication skills to counter the discrimination and disrespectful behaviours amongst health professionals (Nguyen *et al.* 2019: 25). Training of healthcare workers should incorporate the issue of interpersonal relationships of healthcare workers and WWDs.

c) Support from family and friends

Support of family is important in ensuring access to healthcare services for WWDs. Considering the challenges of not having sign language interpreters and shortages of human resources, health systems need to institutionalise having a friend or family member during hospital visits and delivery for WWDs (Peta 2015: 17). The family members will assist with interpretation services and other non-clinical needs of the WWDs.

7.3.1.4 Quality

The quality of maternal healthcare services of WWDs is determined by ensuring that all factors (systemic, structural and personal) are inclusive of the needs of WWDs. The quality of services means that adequate and appropriate healthcare service providers, information, infrastructure and healthcare workers sensitive to the needs of WWDs are available.

7.3.1.5 Policy framework

Policymakers need to include disability rights in the policy framework (Nguyen *et al.* 2019:25). In addition, the South African Human Rights Charter should be fully implemented by the health system to ensure that WWDs access maternal healthcare services.

7.4 SUMMARY OF CHAPTER

Considering the systemic, structural and personal factors when designing maternal healthcare services will not only improve access to maternal healthcare services for WWDs but will also ensure that quality maternal services are provided to WWDs. Overarching these factors is the policy framework which is inclusive of the rights of the pregnant WWDs. The policy framework needs to ensure that the needs of WWDs are mainstreamed and integrated into the planning, development and provision of maternal healthcare services for WWDs. The next chapter presents the conclusion and recommendations of the study.

CHAPTER 8: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

8.1 INTRODUCTION

This chapter summarises the findings, limitations and recommendations for the study. The current study has contributed towards documenting and describing the factors that impact access to maternal healthcare services for women with physical, visual and hearing impairments in the KZN province of South Africa. This information will provide a clearer picture of the challenges that WWDs face when accessing maternal healthcare services which will consequently assist when developing ways to improve access to maternal healthcare services for WWDs.

The study was aimed at exploring and describing the factors that impact access to public maternal healthcare services for WWDs in KZN with the ultimate goal of developing a practice framework for improving WWDs' access to maternal healthcare services. It was based on the research questions presented in the preceding chapters. These research questions emanated from the objectives of the study. Below are the objectives of the study which 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.
- Explore the facilitators of access to maternal healthcare services for women with disabilities.
- Describe how access to maternal healthcare services by WWDs can be improved.

8.2 DISCUSSION OF FINDINGS

The findings in relation to the above-mentioned objectives guided the description of the practice framework to improve WWDs' access to maternal health services. A more detailed summary of the findings is presented in Chapter 5 in Table 5.4. The findings for each objective are described below.

8.2.1 Factors that impact WWDs' access to maternal healthcare services

There are many factors that impact access to maternal health services for WWDs. They are classified into three categories, namely: a) systemic, b) structural and c) structural. The systemic factors include availability of human resources and information on the management of WWDs, information and communication needs of WWDs, referral system, health financing and multidisciplinary approach. Structural factors include infrastructural design and layout, examination beds, sanitary facilities and disability-friendly scales. The personal factors include ability to read and write, availability of companions, the interaction between pregnancy and impairment, own experience with a person with a disability, health worker attitudes towards WWDs and WWDs' attitudes towards healthcare workers as well as empowerment of WWDs. These factors can either positively or negatively impact WWDs' access to maternal healthcare services.

8.2.2 Inhibitors of access to maternal healthcare services for WWDs

Women with disabilities face numerous challenges that hinder them from successfully accessing healthcare services. The main inhibiting factors identified were categorised as a) infrastructural design, b) lack of information on how to handle pregnant WWDs, c) health worker acceptance, d) cost of services and, e) communication challenges. In terms of infrastructural design, most of the facilities are not designed to suit the needs of WWDs, for example, at some healthcare facilities there are no ramps and passages are narrow. Furthermore, the equipment is not disability friendly. Lack of information on how to handle pregnant WWDs led to healthcare workers assuming that all pregnant

WWDs are high risk, marginalising and stigmatising WWDs. The lack of information is exacerbated by the lack of training and evidence on how to handle pregnant WWDs.

Even though maternal healthcare services are for free, the study found out that WWDs incur additional costs as they must travel to higher levels of care that are not in their local areas as well as to have a companion whom they travel with. In addition, communication is a challenge especially for women with hearing impairments as healthcare workers have not undergone sign language training and facilities do have sign language interpreters. The communication challenge is worsened by the fact that the facilities do not have assistive devices which could enhance communication with women with visual as well as women with hearing impairments.

8.2.3 Facilitators of access to maternal healthcare services for WWDs

This study found that support from friends and family, availability of resources and experience were the major categories that facilitated access to maternal healthcare services for WWDs. Family and friends enhanced access for WWDs by providing interpreting services for WWDs with visual impairments and assisting with navigating the facility for WWDs with visual and physical impairments. They also helped with other non-clinical issues such as carrying the WWDs onto and off the high beds. Availability of resources is a great facilitator of access. Women with disabilities need support for different activities, for example, some WWDs will need someone to help with the opening of legs during delivery. There would be a need for a team of healthcare workers to assist each other during the process.

The study also found that the availability of disability-friendly equipment such as adjustable beds enhanced the access for WWDs. As the WWDs' pregnancy may interact with the impairment which can result in a complication, the availability of a multidisciplinary team for inter-professional collaboration is an important factor that enhances access. Having more years in providing

maternal healthcare services proved to be an enhancer of access as healthcare workers became more confident and gained more knowledge on handling pregnant WWDs. Furthermore, healthcare workers who had a relative who had a disability felt more comfortable and confident to provide healthcare services to pregnant WWDs. These healthcare workers felt that they understood the needs of people with disabilities and can relate to WWDs very well.

8.3 THE PRACTICE FRAMEWORK TO IMPROVE WWDs' ACCESS TO MATERNAL HEALTHCARE SERVICES

Considering the many barriers to WWDs' access to maternal healthcare services, a practice framework that illustrates how WWDs' access to maternal healthcare services can be improved is required. Access to maternal healthcare services is important to ensure a reduction in maternal mortality and morbidity. The framework describes how systemic factors, structural factors and personal factors are inter-connected to ensure that WWDs receive quality maternal healthcare services. The systemic, structural and personal factors are influenced by the policy framework which should be inclusive and integrate the needs of pregnant WWDs.

The framework stipulates that adequate and appropriate maternal healthcare service providers who are sensitive to the needs of WWDs must be available at all levels of maternal healthcare facilities. The maternal healthcare service providers should be coupled by a multidisciplinary team of professionals to ensure the inter-professional provision of services to pregnant WWDs. In addition, maternal healthcare services should be structured in disability-friendly manner and furnished with disability-friendly equipment and assistive devices. Adequate and appropriate evidence-based information on disability and pregnancy should be readily available to healthcare workers as well as WWDs. Maternal healthcare services should be financially accessible for WWDs. Furthermore, healthcare services should be geographically and physically accessible for WWDs.

The framework also identifies the need for different stakeholders to work together to empower the WWDs. Empowerment of WWDs helps them speak out and express themselves when they need help and what help they need and also indicate when they are treated with disrespect. In addition, an accompanying family member or friend should be allowed to be always with the WWDs during hospital visits, delivery and post-natal care. The family members and friends could assist with the interpreting for women with hearing impairments and WWDs with visual and physical impairments with navigating the facilities. In order to improve the accessibility of maternal health care services for WWDs, there is need for the health system to consider the above-mentioned factors.

8.4 SUMMARY OF THE STUDY

The study found that the healthcare workers conceptualised access to maternal healthcare services in terms of the systemic, structural and personal factors. These factors either positively or negatively impact WWDs' access to maternal healthcare services. These factors are interconnected, and all determined by the policy framework. Central to the systemic, structural and personal factors is the quality of services.

The study found out that there are numerous challenges that WWDs face in accessing maternal healthcare services. The primary and secondary levels of maternal healthcare services are not adequately prepared to suit the needs of pregnant WWDs. The facilities have shortages of maternal healthcare service providers. The healthcare workers are overwhelmed, and they do not give adequate attention to the pregnant WWDs. An example is where one health worker must attend to five women in labour. Women with disabilities at times require help from more than one healthcare worker which is a challenge when there is only one healthcare worker who is attending to many women concurrently.

The study also found that healthcare workers from all levels of care, midwives, medical officers and gynaecologists do not have adequate information on how to handle pregnant WWDs. Furthermore, there are no evidence-based guidelines on the provision of maternal healthcare services for WWDs. Healthcare workers provide the maternal healthcare services the same way they provide services to pregnant women without disabilities even though pregnant WWDs may have peculiar needs because of their impairments. The lack of information and competency results in healthcare workers lacking confidence in the provision of services of WWDs. The lack of confidence at times leads to healthcare lacking sensitivity to the needs of WWDs and ill-treating the pregnant WWDs.

In addition, the study found that the facilities did not have infrastructure which is designed to suit the needs of pregnant WWDs. The facilities, especially the primary and secondary levels of care did not have adequate ramps, had narrow passages and doorways as well as small consultation rooms which could not fit wheelchairs. The primary and secondary levels of care did not have adjustable beds and assistive devices for WWDs to use to navigate the facilities. Furthermore, the facilities did not have sign language interpreters or porters who would assist with sign language interpretation and navigating the facility respectively.

The study also found that the WWDs were frequently referred to higher levels of care that are far from their local areas. This increases the distance that they travel to access maternal healthcare services. The WWDs frequently travel with a friend or relative who would assist them with navigating the facilities as well as interpreting sign language. This increases the cost of accessing maternal healthcare services for WWDs even though maternal healthcare services are provided for free.

The study found out that the tertiary health facilities had adequate healthcare providers, a multidisciplinary team, adjustable beds and assistive devices. These factors positively impacted access to maternal healthcare services. The

other factors that enhanced access to maternal healthcare services were the availability of a companion, ability to read and write for women with hearing impairments, healthcare worker ability to use sign language, WWDs' ability to speak out whenever they need help and explain what kind of help they need, healthcare worker's length of provision of maternal healthcare services and healthcare worker's having relatives with disabilities were other factors that enhanced WWDs' access to maternal healthcare services.

The research on WWDs access to maternal healthcare services is still very scarce. There is a need for more extensive research on WWDs' access to maternal healthcare services understanding the factors that impact access for pregnant WWDs in order to develop disability-friendly maternal healthcare services. The sustainable development goals (SDGs) advocate for the inclusion of people with disabilities in all the mainstream services including healthcare services. Improving access to maternal healthcare services for WWDs would be a step towards achieving the SDGs as well as reducing maternal mortality and morbidity. Improving services for WWDs will mean that services for women without disabilities will indirectly be improved too. In addition, Section 27 of the Constitution provides that everyone has the right to have access to healthcare services, including reproductive services. Improving access to healthcare services for pregnant WWDs entails the fulfilment of the Constitution.

Considering the low numbers of pregnant WWDs that visit the facilities, having all the maternal healthcare facilities adequately equipped for pregnant WWDs may be a challenge. There may be a need to have selected maternal healthcare facilities that are designed to meet the needs of WWDs, have adequate resources and equipment including sign language interpreters and an interdisciplinary team. These facilities will be well known and all pregnant WWDs can be referred to those facilities. The WWDs can be provided with vouchers to reimburse them for the transport cost as they may have to travel to areas that are not within their communities. In addition, the access to maternal healthcare services could be improved by including pregnant WWDs to be part of the outreach programme. The outreach teams will then include a team of

healthcare workers who provide maternal healthcare services and are sensitive to the needs of pregnant WWDs. Below is a Wordle summary of the study.



Figure 8.1: Wordle summary of the study

8.5 LIMITATIONS OF THE STUDY

Study limitations represent weaknesses within research design that may influence outcomes and conclusions of research (Ross and Zaidi 2019: 261). According to Theofanidis and Fountouki (2018: 57), “study limitations may include assumptions regarding underlying theories, causal relationships, study setting, population or sample, data collection analysis, results, interpretation and corresponding conclusions”. The limitations of the study can be applied to reduce any possible negative impact the study could have. This study had a limited sample size and provided a detailed description of the methodology as Grove, Burns and Gray (2012: 160) outline that the study limitations can be identified before the research study is conducted. The study also anticipated to interview gynaecologists, however, when visiting the district health facility, the

researcher found that the maternal healthcare services were provided by medical officers. As a result, one medical officer was included in the study.

With regard to data collection, the data from healthcare workers which was collected as in-depth interviews was not as detailed as the ones where focus groups were conducted. Due to time constraints amongst the healthcare workers, the in-depth interviews were conducted using focus group guide questions. Data were collected during the free time of the healthcare workers, and it was a challenge to have a group of healthcare workers free at the same time. Furthermore, with the advent of COVID-19, face-to-face interactions were restricted and consequently some of the interviews were conducted telephonically. During the telephonic interviews one tends to miss some information which can be identified through the observation of non-verbal cues.

The findings of the qualitative study cannot be generalised to other settings. This study was designed to be representative of the facilities that were selected and the healthcare workers who work in these facilities as well as the WWDs who seek maternal healthcare services from these facilities.

Another limitation of the study was the use of approaches using structure or predetermined framework to analyse data. This approach is useful where the researchers are aware of the anticipated responses from the participants. The challenge of using a predetermined framework is that it is rigid and can be potentially biased and can severely limit the theme and theory development. For the development of themes and theory for phenomenological studies in this field, studies should utilise both deductive and inductive approaches.

8.6 STRENGTHS OF THE STUDY

The researcher visited the facilities and was introduced to the nursing managers and the obstetric unit managers. These managers introduced the researcher to the midwives during their morning meeting. The researcher then introduced the study to the midwives during the morning meeting. This led the

midwives to trust the researcher and consequently offered to conduct discussions in their free time.

The researcher also collected data from a variety of participants, that is, midwives, gynaecologists and the WWDs and from different levels of care: primary, secondary and tertiary. This allowed for triangulation of data sources. Individual in-depth interviews were conducted with all the 12 WWDs and three focus groups were conducted with midwives and in-depth interviews were conducted with six of the midwives and four gynaecologists and one medical officer.

8.7 RECOMMENDATIONS

The study findings revealed that stakeholders like the policymakers, civil society organisations, healthcare workers and WWDs have a role to play to improve WWDs' access to maternal healthcare services. These stakeholders can contribute in different ways to ensure access to maternal healthcare services for WWDs.

8.7.1 Policymakers

Policymakers need to design policies that ensure mainstreaming of WWDs in maternal healthcare services. These policies should include renovating the maternal healthcare facilities so that they can accommodate the WWDs without any challenges. In addition, the policies should incorporate the equipping of maternal healthcare facilities with disability-friendly equipment and assistive devices. Considering that it may take a long time due to financial constraints in the economy in general in particular the public health sector to have all maternal healthcare facilities renovated and be adequately equipped with disability-friendly equipment. Nevertheless, the suggested changes can be effected utilising an incremental approach whereby a few facilities per district can be selected which will be fully resourced and designed to suit the needs of pregnant WWDs. In addition, the government may partner with the corporate world to improve the existing infrastructure. The government can incentivise the corporate world by formulating fiscal policies that will ensure that corporate

world stakeholders will receive high tax refunds. The partnership between government and the corporate world should also address issues of the shortage of health care workers in the public maternal health care system. If this recommendation is effected successfully, WWDs will easily access public maternal health facilities, resulting in a reduction in maternal mortality, which is one of the challenges facing low and middle-income countries including South Africa.

Since most WWDs who make access public maternal health services belong to the low income bracket it would be vital to support the pregnant WWDs with vouchers to use for transport costs to access these facilities. These vouchers will be used by WWDs in using transport suitable for transporting people with disabilities. Furthermore, pregnant WWDs could be included as part of the outreach programme. This will assist in WWDs accessing maternal healthcare services in their localities and visiting healthcare facilities only when there is a need for further services that cannot be provided by the outreach team.

Furthermore, the policymakers should advocate for the training of healthcare workers to include how to handle pregnant WWDs as well as the training in sign language. The training could be incorporated in the pre-service or in-service training. Considering that it may take time for most healthcare workers to learn sign language and to have adequate healthcare workers available at the facilities all the time, there may be a need to institutionalise that WWDs should have a companion every time they visit or are admitted at the facility. The companion will assist with the interpretation and navigation of the facility. Furthermore, policymakers should ensure that healthcare workers are provided with evidence-based guidelines on the provision of maternal healthcare services for WWDs. Policymakers should design policies that ensure the employment of WWDs in key positions of the maternal healthcare sector so that they can have an input in the decision-making of the maternal healthcare sector. In addition, policy makers may need to reconsider the bonding policy of

newly qualified nurses to ensure adequate number of health care workers in public maternal health care services.

8.7.2 Civil society

Civil society organisations should advocate for the rights of people with disabilities and sensitise the communities on the needs of the people with disabilities. The sensitisation should also target the healthcare workers and WWDs. In addition, civil society organisations should work with government departments to empower the WWDs economically by involving them in some income-generating projects. Women with disabilities' empowerment should also include capacitating them on how they can express themselves when they need help and when they are not treated well.

8.7.3 Healthcare workers

Healthcare workers need to be trained on how to handle pregnant WWDs. They need to be sensitised on the needs and on how to relate with WWDs. Furthermore, they need to have inter-professional platforms where they can discuss and share experiences on how pregnant WWDs can be assisted. The healthcare workers will need to implement the policies that mainstream disability that have been developed by policymakers.

8.7.4 Women with disabilities

Women with disabilities need to be empowered economically and on how to speak out for their needs. They need to be able to inform the healthcare workers what their needs are as they are the experts of their bodies.

8.7.5 Further research

The study findings revealed a paucity in research on the WWDs' access to maternal healthcare. Therefore, there is a need for more funding for research in improving the accessibility of maternal healthcare services for WWDs. Below

are recommendations regarding further research based on the findings of this study:

- A study is needed to explore the maternal healthcare needs and utilisation of maternal healthcare services according to the type of impairment.
- This study revealed that attitudes of healthcare workers to WWDs and attitudes of WWDs towards midwives had an impact on access to maternal healthcare services. Further research is needed to explore the relationship between healthcare providers and WWDs and the impact of the relationship on access to maternal healthcare services.
- This study also revealed that healthcare workers' beliefs, attitudes and knowledge impact access to maternal healthcare. There is a need for a study to explore the knowledge, attitudes and beliefs of healthcare service providers regarding maternal healthcare for WWDs.
- More research is needed regarding the impact of inter-professional cooperation in the provision of maternal healthcare services for WWDs.

8.8 SUMMARY OF THE CHAPTER

The current study contributed towards a better understanding of the factors that impact WWDs' access to maternal healthcare services. It provided an analysis of the barriers and WWDs' access to maternal healthcare services. The study then provided a practice framework that could improve WWDs' access to maternal healthcare services by referring to the conceptual framework of assessing access to healthcare services.

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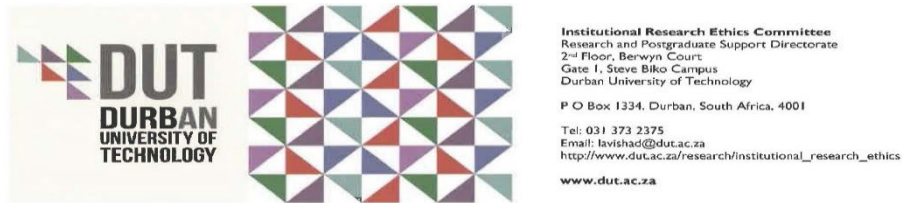
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APPENDICES

Appendix 1: University Ethics clearance



9 October 2018

Ms D Mheta
5 Elm Gardens
17 Cromwell Road
Glenwood
Durban

Dear Ms Mheta

A practice framework to improve accessibility of maternal health care services for women with disabilities in KwaZulu-Natal, South Africa

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC



Appendix 2a: Letter of permission to the Health District Manager

5 Elm Gardens
17 Cromwell Road
Glenwood
4001
[Date]

The District Manager
EThekweni Health District
Private Bag X54318
Durban
4000

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a student registered for a PhD in Health Sciences at the Durban University of Technology. The topic of my study is '*A practice framework to improve accessibility of maternal healthcare services for women with disabilities in the province of KwaZulu-Natal, South Africa*'.

A qualitative, case design will be utilised to explore the factors that impact on accessibility of maternal healthcare services for women with disabilities. The data sources will be women with disabilities who are pregnant, have had a baby, miscarriage or stillbirth and maternal healthcare service providers with one year work experience in providing maternal healthcare services. In-depth one on one interviews will be undertaken with women with disabilities. Data from healthcare workers will be collected through focus group discussions. The focus group discussion will take approximately 45 to 60 minutes. Healthcare facilities were selected to represent different levels of healthcare services. The following healthcare facilities were selected for the study; Cator Manor Community Healthcare Centre, Wentworth Hospital, Addington Hospital, King Edward VIII and Inkosi Albert Luthuli Hospital. Confidentiality and anonymity of institutions will be maintained at all times. Feedback will be given on completion of the study

Permission is hereby requested to conduct the study at the sites mentioned above. Ethical approval to conduct the study will be obtained from the Durban University of Technology Institutional Research Ethics Committee. The researcher will ensure that service delivery is not interrupted during data collection process by collecting data during tea and lunch breaks. A copy of the summary of the research proposal is enclosed. Your support and permission to conduct the study at the facilities mentioned above will be appreciated. Please do not hesitate to contact my supervisor, Prof MN. Sibiyi if you have questions. Her email address is nokuthulas@dut.ac.za

Yours sincerely

.....
Mrs D. Mheta (PhD student)
Email: dmheta@gmail.com
Cell: 071 011 0928

Appendix 2b: Approval letter from the Health District Manager



DIRECTORATE: CORPORATE SERVICES

83 King Cetshwayo Highway
Mayville, Durban, 4001
Tel: 031 240 5455 Email: avashri.harrichandparsad@kznhealth.gov.za
www.kznhealth.gov.za

ETHEKWINI HEALTH DISTRICT OFFICE

30 July 2018

Dear Mrs D Mehta

Re: Permission To Conduct Research at eThekweni District Facilities.

This letter serves to confirm that your application to conduct the research study titled "A practice framework to improve accessibility of maternal health care services for women with disabilities in KwaZulu-Natal, South Africa." in the eThekweni district at the following health care facilities has been recommended:

Cato Manor CHC
Wentworth Hospital
Addington Hospital
King Edward VIII Hospital
Inkosi Albert Luthuli Central Hospital

Please also note the following:

1. Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for approval
2. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted,
3. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
4. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
5. Ensure that this office is informed before you commence your research
6. The District Office/Facility will not provide any resources for this research
7. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
8. You will be expected to provide feedback on your findings to the District Office/Facility

Yours sincerely

Dr. A. Harrichandparsad
pp Ms. T. P. Msimango
Chief Director
eThekweni Health District

Appendix 3a: Letter of permission to the Health Provincial Manager

5 Elm Gardens
17 Cromwell Road
Glenwood
4001
[Date]

The Department of Health
KwaZulu-Natal Province
Private Bag X9051
Pietermaritzburg
3200

Dear Dr Lutge

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a student registered for a PhD in Health Sciences at the Durban University of Technology. The topic of my study is '*A practice framework to improve accessibility of maternal healthcare services for women with disabilities in the province of KwaZulu-Natal, South Africa*'.

A qualitative, case study design will be utilised to explore the factors that impact on accessibility of maternal healthcare services for women with disabilities. The data sources will be women with disabilities who are pregnant, have had a baby, miscarriage or stillbirth and maternal healthcare service providers with one year work experience in providing maternal healthcare services. In-depth one on one interviews will be undertaken with women with disabilities. Data from healthcare workers will be collected through focus group discussions. The focus group discussion will take approximately 45 to 60 minutes. Healthcare facilities were selected to represent different levels of healthcare services. The following healthcare facilities were selected for the study; Cator Manor Community Healthcare Centre, Wentworth Hospital, Addington Hospital, King Edward VIII and Inkosi Albert Luthuli Hospital. Confidentiality and anonymity of institutions will be maintained at all times. Feedback will be given on completion of the study.

Permission is hereby requested to conduct the study at the sites mentioned above. Ethical approval to conduct the study will be obtained from the Durban University of Technology Institutional Research Ethics Committee. The researcher will ensure that service delivery is not interrupted during data collection process by collecting data during tea and lunch breaks. A copy of the summary of the research proposal is enclosed. Your support and permission to conduct the study at the facilities mentioned will be appreciated. Please do not hesitate to contact my supervisor, Prof MN. Sibiya if you have questions. Her email address is nokuthulas@dut.ac.za

Yours sincerely

.....
Mrs D. Mheta (PhD student)
Email: dmheta@gmail.com
Cell: 071 011 0928

Appendix 3b: Approval letter from the KwaZulu-Natal Department of Health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

**Health Research & Knowledge
Management**

HRKM Ref: 316/18
NHRD Ref: KZ_201808_014

Dear Ms D. Mheta
DUT

Approval of research

1. The research proposal titled '**A practice framework to improve accessibility of maternal health care services for women with disabilities in KwaZulu-Natal, South Africa**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Addington, King Edward VIII, Wentworth and Inkosi Albert Luthuli Central Hospital; Cato Manor CHC.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 27/07/18

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4a: Letter of permission to the Chief Executive Officers

5 Elm Gardens
17 Cromwell Road
Glenwood
4001
[Date]

The Chief Executive Officer
XXXXX Hospital
XXXX
XXXX

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a student registered for a PhD in Health Sciences at the Durban University of Technology. The topic of my study is '*A practice framework to improve accessibility of maternal healthcare services for women with disabilities in the province of KwaZulu-Natal, South Africa*'.

A qualitative, case study design will be utilised to explore the factors that impact on accessibility of maternal healthcare services for women with disabilities. The data sources will be women with disabilities who are pregnant, have had a baby, miscarriage or stillbirth and maternal healthcare service providers with one year work experience in providing maternal healthcare services. In-depth one on one interviews will be undertaken with women with disabilities. Data from healthcare workers will be collected through focus group discussions. The focus group discussion will take approximately 45 to 60 minutes. Healthcare facilities were selected to represent different levels of healthcare services. The following healthcare facilities were selected for the study; Cator Manor Community Healthcare Centre, Wentworth Hospital, Addington Hospital, King Edward VIII and Inkosi Albert Luthuli Hospital. Confidentiality and anonymity of institutions will be maintained at all times. Feedback will be given on completion of the study.

Permission is hereby requested to conduct the study at your facility. Ethical approval to conduct the study will be obtained from the Durban University of Technology Institutional Research Ethics Committee. The researcher will ensure that service delivery is not interrupted during data collection process by collecting data during tea and lunch breaks. A copy of the summary of the research proposal is enclosed. Your support and permission to conduct the

study at your facility will be greatly appreciated. Please do not hesitate to contact my supervisor, Prof MN. Sibiya if you have questions. Her email address is nokuthulas@dut.ac.za

Yours sincerely

.....
Mrs D. Mheta (PhD student)
Email: dmheta@gmail.com
Cell: 071 011 0928

Appendix 4b: Approval letter from the Chief Executive Officers of King Edward Hospital



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO
KING EDWARD VIII HOSPITAL

Private Bag X02, CONGELLA, 4013
Corner of Rick Turner (Francois Road) & Sydney Road
Tel: 031-3603853, Fax: 031-2061457, Email: reloice.khuzwayo@kznhealth.gov.za
www.kznhealth.gov.za

Ref.: KE 2/7/1/(67/2018
Enq.: Mrs. R. Sibiya
Research Programming

26 November 2018

Ms. D. Mheta
5 Elm Gardens
17 Cromwell Road
Glenwood
DURBAN

Dear Ms. Mheta

Protocol: "A practice framework to improve accessibility of maternal health care services for women with disabilities in KwaZulu-Natal, South Africa"

Your request to conduct research at King Edward VIII Hospital has been approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgment in the study on all publications and reports and also kindly present a copy of the publication or report on completion.

Before commencement:

- * Discuss your research project with our relevant Clinical Head/Assistant Nursing Manager
- * Sign an indemnity form at Room8, CEO's Complex, Admin. Block.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

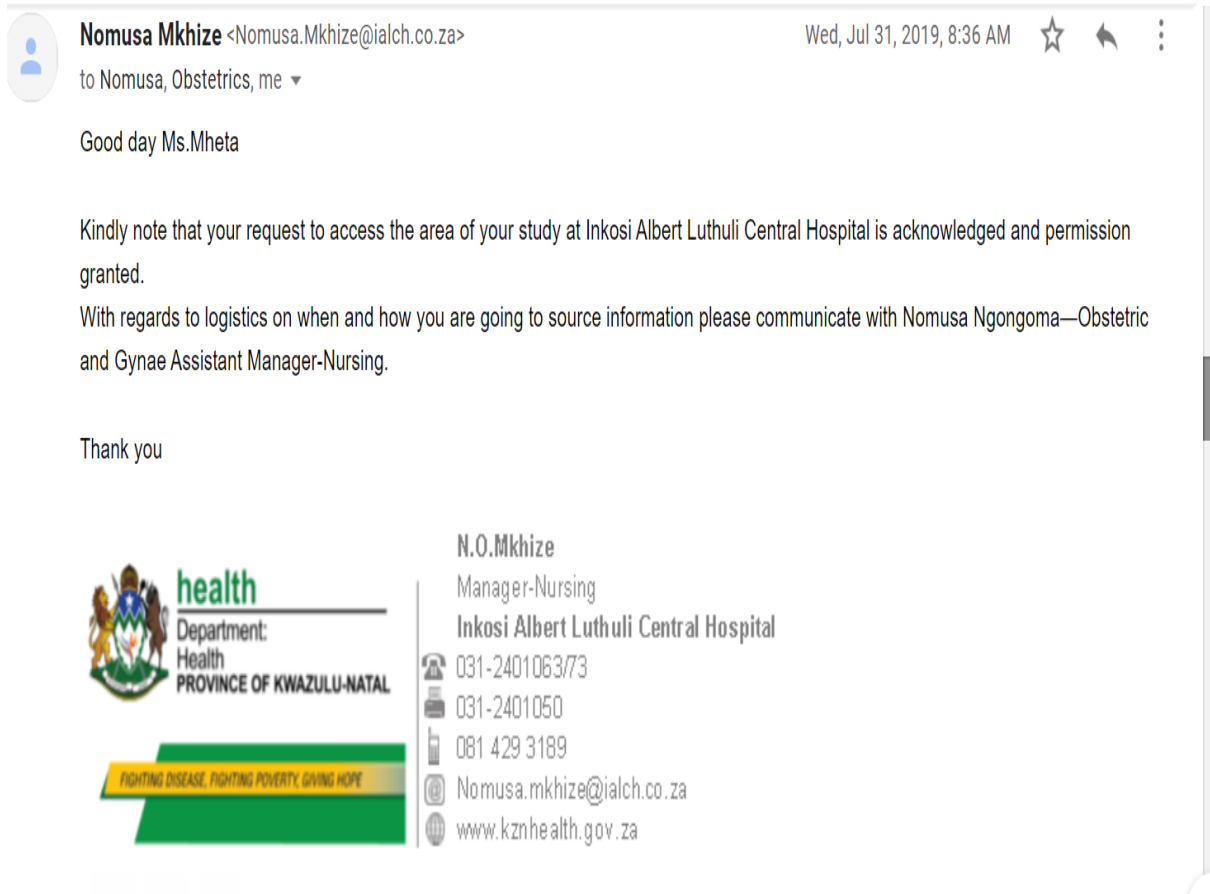
SUPPORTED/NOT-SUPPORTED

DR. SA MOODLEY
ACTING SENIOR MEDICAL MANAGER

27/11/18
DATE

Fighting Disease. Fighting Poverty. Giving Hope.

Appendix 4c: Approval letter from the Chief Executive Officers of Inkosi Albert Luthuli



Appendix 4d: Approval letter from the Chief Executive Officers of Cator Manor CHC



Appendix 4e: Approval letter from the Chief Executive Officers of Addington Hospital



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ADDINGTON HOSPITAL

P.O. BOX 977
DURBAN
4000
Tel: 031-327-2970 Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Reference: 9/2/3/R

Date: 7th November 2018

Principal Investigator:

➤ **Ms D Mheta**

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "A PRACTICE FRAMEWORK TO IMPROVE ACCESSIBILITY OF MATERNAL HEALTH CARE SERVICES FOR WOMEN WITH DISABILITIES IN KWAZULU-NATAL, SOUTH AFRICA"

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.

**DR A ARON
ACTING HOSPITAL MANAGER
ADDINGTON HOSPITAL**

Appendix 4f: Approval letter from the Chief Executive Officers of Wentworth Hospital



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

1 Boston Road, Jacobs 4025
Private Bag, Jacobs 4025
Tel: 031-460 5000 Fax: 031-4689654
www.kznhealth.gov.za

DIRECTORATE:

WENTWORTH HOSPITAL
PRIVATE BAG
JACOBS 4026

Reference : Research Protocol
Enquiries: Dr. S. Kader
Telephone: 031- 460 5006/7

E Mail: Suriya.Kader@kznhealth.gov.za

Date: 05TH DECEMBER 2018

MS D MHETA
5 ELM GARDENS
17 CROMWELL ROAD
GLENWOOD
DURBAN

Email: dmheta@gmail.com

Dear Ms. Mheta

RE: A PRACTICE FRAMEWORK TO IMPROVE ACCESSIBILITY OF MATERNAL HEALTH CARE SERVICES FOR WOMEN WITH DISABILITIES IN THE PROVINCE OF KWAZULU NATAL, SOUTH AFRICA.

I have pleasure informing you that permission has been granted to you to conduct the above research.

Kindly take note of the following information before you continue:-

1. Please adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the Kwazulu Natal Department of Health.
3. Kindly ensure that this office is informed before you commence your research.
4. The hospital will not provide any resources for this research.
5. You will be expected to provide feedback once your research is complete to the Chief Executive Officer.

Yours faithfully

DR. S.B. KADER
HOSPITAL MANAGER

Appendix 5a: Permission letter to Department of Social Development

5 Elm Gardens
17 Cromwell Road
Glenwood
4001
[Date]

Department of Social Development
Private Bag X9144
Pietermaritzburg
3200

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a student registered for a PhD in Health Sciences at the Durban University of Technology. The topic of my study is” ‘*A practice framework to improve accessibility of maternal healthcare services for women with disabilities in the province of KwaZulu-Natal, South Africa*’.

A qualitative case study design will be utilised to explore the factors that influence accessibility of maternal healthcare services for women with disabilities. The data sources will be women with disabilities who are pregnant, have had a baby, miscarriage or stillbirth and maternal healthcare service providers with one-year work experience in providing maternal healthcare services. In-depth one on one interviews will be undertaken with women with disabilities. The in-depth interviews will be between forty-five minutes and one hour. Healthcare facilities were selected to represent different levels of healthcare services. The following healthcare facilities were selected for the study; Cator Manor Community Healthcare Centre, Wentworth Hospital, Addington Hospital, King Edward VIII and Inkosi Albert Luthuli Hospital. “Confidentiality and anonymity of participants will be maintained at all times. Feedback will be given on completion of the study.

Permission is hereby requested for a database of women with disabilities who are pregnant, have had a baby, miscarriage or stillbirth in the previous five years. “Ethical approval to conduct the study will be obtained from the Durban University of Technology Institutional Research Ethics Committee”. The interviews with women with disabilities will be undertaken in their homes, at a healthcare facility or at the offices of the organisations that they are affiliated with. A copy of the summary of the research proposal is enclosed. Your support

and permission to conduct the study with the women with disabilities will be greatly appreciated. Please do not hesitate to contact my supervisor, Prof MN. Sibiya if you have questions. Her email address is nokuthulas@dut.ac.za.

Yours sincerely

.....
Mrs D. Mheta (PhD student)
Email: dmheta@gmail.com
Cell: 071 011 0928

Appendix 5b: Permission letter from Department of Social Development

		social development Department: Social Development PROVINCE OF KWAZULU-NATAL
FAX	: (033) 264 2075	HUMAN RESOURCE DEVELOPMENT
Telephone/ Ucingo /Telefoon	: (033) 264 2078	174 Mayors Walk
Enquiries / Imibuzo / Navrae	: Mr VV Gumede	Private Bag x9144
E-mail	: Velaphi.Gumede@kznsocdev.gov.za	Pietermaritzburg
Reference /Inkomba/ Navrae	: S.6/2/1	3200

Ms D. Mheta
5 Elm Gardens
17 Cromwell Road
Glenwood
Durban

Dear Ms Mheta

PERMISSION TO CONDUCT RESEARCH UNDER NPOs FUNDED BY DSD

This letter has reference

Kindly be informed that permission has been granted by the Head of Department for you to approach NPOs funded by the Department for the purpose of conducting research in Durban area for you to fulfill the requirement of your study.

The permission authorizes you to:-

- (a) Approach and distribute your survey questionnaires to the personnel willing to participate in order to solicit information intended for your research; and
- (b) Interview management at their consent deemed relevant to your research project and maintain high level of confidentiality.
- (c) Share your findings with the department.

Wishing you success during your research project.

Yours Faithfully

MS NG KHANYILE
HEAD OF DEPARTMENT
Date: 04/10/2018

Appendix 6a: Letter of information for women (English)



Dear Participant

Thank you for agreeing to participate in this study.

Title of the Research Study: A practice framework to improve the accessibility of maternal healthcare services for women with disabilities in the province KwaZulu-Natal, South Africa.

Principal Investigator/s/researcher Ms D. Mheta, MPH.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor) and Dr P.B. Nkosi, PhD: Health Sciences (Co-supervisor).

Brief Introduction and Purpose of the Study: The proposed study aims at describing the barriers and facilitators of access to public maternal healthcare services for women with disabilities, in KwaZulu-Natal, with the ultimate goal of proposing a framework for improving women with disabilities' access to maternal healthcare services in South Africa. South Africa is one of the countries striving towards universal access to healthcare services. While access to maternal healthcare services is essential to ensure the reduction of maternal mortality, many vulnerable women are facing numerous challenges in accessing maternal healthcare services.

Outline of the Procedures: You are kindly requested to participate in an interview. The interview questions focus on your experiences in accessing maternal healthcare services. The interview will be conducted by the researcher with the help of a research assistant who is fluent in both English and isiZulu since the researcher is not fluent in isiZulu. The interviews would be under taken in a quiet room at the selected facilities. The interview session will take between 45 minutes to one-hour. The interviews will be audio recorded and the researcher will be documenting some notes.

Risks or Discomforts to the Participant: The study does not involve any physical risk or cause physical discomfort to women with disabilities.

Benefits: A practice framework to improve accessibility of maternal healthcare services will be developed. If this framework is used then you may have improved accessibility of maternal healthcare services as well as other healthcare services.

Reason/s why the Participant May Be Withdrawn from the Study: Contribution will be voluntary and you can withdraw at any given time without any opposing consequences and will be not required to give a reason.

Remuneration: There would be no remuneration to you

Costs of the Study: You will sustain no expenses associated with the study.

Confidentiality: The information provided will be kept strictly confidential and will remain anonymous. The interview does not comprise names and any personal identification details.

Research-related Injury: There are no identified or foreseen risks and discomforts related to you in this study, nevertheless, if so, no compensation will be presented.

Persons to Contact in the Event of Any Problems or Queries”: Please contact the researcher Doreen Mheta, Tel number 071 011 0928, my supervisor Prof M.N Sibiya, Tel number 031-373 2704), my co-supervisor Dr P.B. Nkosi, Tel number 031-373 2509 or the “Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031-373 2577 or carinn@dut.ac.za

Isengezo 6b: Incwadi yolwazi yabantu besifazane



Sawubona

Ngiyabonga ngokuba uvume ukubamba iqhaza kulesi sifundo.

Isihloko socwaningo lwesifundo: Indlela yokwenza ethile ehlose ukuthuthukisa ukutholakala kalula kwezinsiza zokuzala ezinakekela abantu besifazane abaphila nokukhubazeka ngokwezempilo kwisifundazwe saKwaZulu-Natali, eNingizimu Afrika.

Umphenyi omkhulu/Umcwaningi: UNkk D. Mheta, MPH.

Umhloli: USolwazi M.N. Sibiyi, D Tech Nursing (Umhloli) kanye noDokotela P.B. Nkosi, PhD: Health Sciences (Umhloli wesibili).

Isingeniso kanye nenhloso yesifundo: Lesi sifundo sihlose ukubheka izithiyi kanye nabalekeleli bezinsiza zokunakekelwa ngokwezempilo eziphathelele nokuzala kubantu besifazane abaphila ngokukhubazeka KwaZulu-Natali, konke lokhu kwenziwa ngenhloso yokuthi kuqhanyukwe nohlelo oluzokwazi ukuthuthukisa indlela abantu besifazane abaphila ngokukhubazeka abazokwazi ngayo ukuthola usizo oluhlobene nezinsiza zokuzala eNingizimu Afrika. INingizimu Afrika ingelinye lamazwe asebenza kanzima ekuqinisekiseni ukuthi wonke umuntu uyakwazi ukuthola usizo oluhlobene nemisebenzi yezempilo. Njengoba uhlelo lokuthi abantu bathole usizo ngezinto eziqinisekisiwe nokuzala lusemqoka kubalulekile ukuthi kuncishiswe izinga lokushona kwabantu besifazane abazithwele, baningi kakhulu abantu besifazane abazisulu zokungalutholi usizo oluhlobene nokunakekelwa ngokwezempilo okuphathelele nokuzala.

Ukuchazwa kwendlela yenqubo: Uyanxuswa ukuba ubambe iqhaza kwinhlolelokhono ehlobene nalolu cwaningo. Imibuzo yale nhlolelokhono igxile kakhulu ezintweni osudlule kuzo mayelana nokuthola usizo oluhlobene nezempilo eziphathelele nokuzala. Inhlolelokhono izolawulwa ngumcwaningi elekelelwa ngumsizi wocwaningo okwaziyo ukukhuluma isiNgisi nesiZulu ngokulinganayo lokho kwenziwa ngoba umcwaningi akakwazi ukukhuluma isiZulu ngokuphelele. Inhlolelokhono izokwenziwa egunjini elithule kwezinye

zezindawo ezizokhethwa. Inhlolokhono ngayinye izothatha imizuzu engama-45 kuya ehoreni elilodwa. Inhlolokhono izoqoshwa kanti umcwaningi uzobe ebhala phansi amanye amaphuzu abalulekile.

Ubungozi noma ukungakhululeki kombambiqhaza: Lesi sifundo asinabo ubungozi noma ukungakhululeki ngokomzimba kubantu besifazane abaphila ngokukhubazeka.

Izinzuzo: Kuzoqhanyukwa nendlela yokwenza ethile ehlobene nokuthuthukiswa kokutholakala kalula kosizo oluhlobene nezinsiza zezempilo. Uma kuqhanyukwa nale ndlela lokho kuchaza ukuthi ungaba nendlela engcono kakhulu yokuthola izinsiza zezempilo ezihlobene nokuzala kanye nezinye izinsiza zokunakekelwa ngokwezempilo.

Izizathu ezingadala ukuba obambe iqhaza ashenxe ocwaningweni: Ukubamba iqhaza ukwenza ngokuthanda kwakho kanti ungasula noma ngasiphi isikhathi ngale kokuthi kuzoba nezinkinga ngalokho futhi angeke uze uphoqekele ukunikeza izizathu.

Inkokhelo: Ayikho inkokhelo ozonikezwa yona.

Izindleko zesifundo: Akukho zindleko ozozithwala ngokubamba kwakho iqhaza kulesi sifundo.

Ukuvikelwa kwesithunzi negama lobambiqhaza: Ulwazi olunikezelayo luzogcinwa luyimfihlo futhi igama lakho lizovikelwa njalo. Inhlolokhono ayiwafaki amagama kanye neminingwane eqondene nomuntu ngqo.

Ukulimala okuhlobene nocwaningo: Abukho ubungozi obubonakele nobungahle bukwehlele ngenxa yalolu cwaningo, kodwa ke uma kwenzeka, asikho isinxephezelo esiyonikezwa.

Abantu abangathintwa uma kukhona izinkinga noma kunemibuzo ethize: Uyacelwa ukuba uxhumane nomcwaningi uNkk Doreen Mheta, Inombolo yocingo-071 011 0928, umhloli uSolwazi M.N Sibiya, Inombolo yocingo-031-373 2704), umhloli wesibili uDokotela P.B. Nkosi, inombolo yocingo 031-373-2509 noma uMabhalane we-Institutional Research Ethics ku 031-373-2375. Izikhalazo zingabikwa kuMqondisi we: Research and Postgraduate Support, uSolwazi C. Napier ku-031-373 2577 noma ku- carinn@dut.ac.za

Appendix 7: Letter of information for healthcare workers



Dear Participant

Thank you for agreeing to participate in this study.

Title of the Research Study: A practice framework to improve the accessibility of maternal healthcare services for women with disabilities in the province KwaZulu-Natal, South Africa.

Principal Investigator/s/researcher Ms D. Mheta, MPH.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor) and Dr P.B. Nkosi, PhD: Health Sciences (Co-supervisor).

Brief Introduction and Purpose of the Study: The proposed study aims at describing the barriers and facilitators of access to public maternal healthcare services for women with disabilities, in KwaZulu-Natal, with the ultimate goal of proposing a framework for improving women with disabilities' access to maternal healthcare services in South Africa. South Africa is one of the countries striving towards universal access to healthcare services. While access to maternal healthcare services is essential to ensure the reduction of maternal mortality, many vulnerable women are facing numerous challenges in accessing maternal healthcare services.

Outline of the Procedures: You are requested to participate in the focus group discussions, which will comprise other maternal health service providers (midwives, gynecologists and obstetricians) to discuss the factors that impact on their provision of good quality of maternal healthcare services to women with disabilities. The researcher will hold the focus group discussions with the assistance of a research assistance and the discussions will last between 45 minutes and one hour. Five to six focus group discussions will be held with approximately 40 maternal health service providers. Each group will have approximately 6-8 participants to allow for the robust discussion on the topic. The focus

group discussions will be audio recorded. The research assistant will also be taking down some notes during the discussions.

Risks or Discomforts to the Participant: The study does not involve any physical risk or cause physical discomfort to you.

Benefits: A practice framework to improve accessibility of maternal health services will be developed. If this framework is used then you will be able to provide quality accessible maternal healthcare services to women with disabilities.

Reason/s why the Participant May Be Withdrawn from the Study: Contribution will be voluntary and you can withdraw at any given time without any opposing consequences and will be not required to give a reason.

Remuneration: There would be no remuneration to you

Costs of the Study: You will sustain no expenses associated with the study.

Confidentiality: The information you will provide will be kept strictly confidential and will remain anonymous. The interview does not comprise names and any personal identification details.

Research-related Injury: There are no identified or foreseen risks and discomforts related to you in this study, nevertheless, if so, no compensation will be presented.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher Ms Doreen Mheta, Tel number 071 011 0928, my supervisor Prof M.N Sibiya, Tel number 031-373 2704), my co-supervisor Dr P.B. Nkosi, Tel number 031-373 2509 or the Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031-373 2577 or carinn@dut.ac.za

Appendix 8a: Consent



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms D. Mheta about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant Thumbprint	Date	Time	Signature / Right

I, Ms Doreen Mheta herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	Date	Signature

_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

_____	_____	_____
Full Name of Legal Guardian (If applicable)	Date	Signature

Isengezo 8b: Imvume



“Isitatimende sesivumelwano sokuba yingxeny yocwaningo:

- Ngiaqinisekisa ukuthi ngazisiwe ngumcwaningi, Nkk D. Mheta ngobunjalo ukuphathwa, inzuzo nokungaba yingozi ngalolucwaningo-inombolo ye Research Ethics Clearance_____.
- Ngiyitholile, ngayifunda ngaqonda ngokubhalwe ngenhla (Encwadini yolwazi) maqondana nocwaningo.
- Ngiyazi ukuthi imiphumela yocwaningo neminingwane yami mayelana nobulili, ubudala, usuku lokuzalwa, iziqalo zamagama ami nesifo esingiphethe angeke kuvezwe kumbiko wocwaningo.
- Ngenxa yezidingo zocwaningo, ngiyavuma ukuthi ulwazi oluqoqwe ngumcwaningi kulolucwaningo angalusebenzisa nge computer.
- Ngingayihoxisa imvume nokuba yingxeny yokuba yingxeny yalolucwaningo ngaphandle kokucwaswa.
- Ngibe nethuba elanele ukubuza imibuzo ngakho ke ngiyavuma ukuthi ngikulungele ukuba yingxeny yalolucwaningo.
- Ngiaqonda ukuthi ngiyokwaziswa ngokusha okutholakele kulolucwaningo ngenxa yokuzibandakanya kwami nalo.

Igama eliphelele loyingxeny yocwaningo
Sayina/ Isithupha sangasokudla

Usuku

Isikhathi

Mina Doreen Mheta ngiaqinisekisa ukuthi lona obhalwe ngasenhla oyingxeny yocwaningo wazisiwe ngobunjalo, ukuphatha nokungaba yingozi obuphathelene nalolucwaningo.

Igama lomcwaningi

Usuku

Sayina

Igama lofakazi
(Uma kusesidingo)

Usuku

Sayina

Igama eliphelele longamele ingane ngokomthetho

Usuku

Sayina

”

Appendix 9a: Interview guide for women with disabilities (English)

Participant Number:

SECTION A: PERSONAL INFORMATION

Age _____

Marital status _____

Occupation _____

Education level _____

Background information on the respondent

1. Please tell me briefly about yourself.
 - a. History of the disability.
 - b. Main challenges faced as a disabled girl and then woman.
2. Maternal history experience
 - a. How many pregnancies have you had?
 - b. How many children do you have?
 - c. What happened to other child or children? If less than the number of pregnancies.
 - d. Where did you deliver your child/children?
 - e. If you did not use a healthcare facility for delivery, why did you seek help elsewhere and not at the health facility?

SECTION B: ACCESS TO HEALTH FACILITIES

3. Have you visited a healthcare facility for any maternal healthcare services
 - a. What maternal healthcare services did you seek?
 - b. What was the accessibility of services provided and attitude of service providers like?
 - c. How did you get to the maternal healthcare facility? How did it make you feel?

SECTION C: EXPERIENCES WITH THE MATERNAL HEALTHCARE SERVICES

4. Could you share with me the particular experiences related to visiting the healthcare facilities while you were pregnant?
 - a. Probe home delivery if any and reasons for this
 - b. How was the physical access of the scales, labour and delivery rooms?
 - c. What kind of assistance did you need during delivery e.g. interpreter?
 - d. What other services did you receive?

- e. Did you have any procedure performed without your consent? If yes describe the procedure and the effect of the procedure?
 - f. How have the experiences at maternal healthcare facilities in child birth affected your life?
- 5. Are there instances that you have required maternal healthcare services from healthcare facilities but decided not seek the services. What was the reason for not seeking maternal services?
 - 6. How have your experiences at the maternal healthcare facility affected your views and your decisions about maternal healthcare?
 - 7. What should be done at maternal healthcare facilities in-order to make life more bearable for women like yourself and others with disability?

Thank you for your cooperation and time

Isithasiselo 9b: Indlela abazobuzwa ngayo imibuzo abesifazane abakhubazekile (IsiZulu)

Inombolo yobamba iqhaza kucwaningo:

ISAHLUKO A: IMINININGWANE YAKHO

Iminyaka yakho yobudala _____

Ushadile noma awushadile _____

Ibanga lemfundo yakho _____

Umsebenzi owenzayo _____

Imininingwane yobambe iqhaza

1. Ngicela ungitshele kafushane mayelana nawe.
 - a. Umlando ngokukhabazeka kwakho.
 - b. Izingqinamba ezinzima owawubhekene nazo useyintombazane nowubhekene nazo manje usukhulile
2. Osuke wahlangabezana nakho uma ukhulelwe
 - a. Usakhulelwe kangaki?
 - b. Unezingane ezingaki?
 - c. Uma usuke wakhulelwa okudlula inani lezingane onazo njengamanje, kwenzekalani kwenye ingane noma kwezinye izingane?
 - d. Wabelethela kuphi?
 - e. Uma ungabelethelanga esikhungweni esibhekelele ukubelethisa, kungani wafuna usizo lapho owabelethela khona wayeka esikhungweni sezempilo lapho kusizwa khona ngokubelethisa?

ISAHLUKO B: UKUFINYELELA EZIKHUNGWENI SEZEMPILO

3. Usuke waya esikhungweni sezempilo mayelana nanoma yini ephathelene nokukhulelwa?
 - a. Wacela ukusizwa ngani ephathelene nokukhulelwa?
 - b. Wabona kubanjani ukuthola usizo owalutholayo futhi bakuphatha kanjani ababekusiza?
 - c. Wafinyelela kanjani esikhungweni esibhekelele ukusiza abakhulelwe? Wazizwa unjani emva kwalokho?

ISAPHLUKO C: OSUWAKE WAHLANGABEZANA NAKHO UMA UTHOLA USIZO EZIKHUNGWENI EZIBHEKELELE UKUSIZA ABAKHULELWE

4. Ungangitshela owahlangabezana nakho ngesikhathi uye esikhungweni sezempilo ukhulelwe?
 - a. Ukubuza mayelana nokubelethela ekhaya uma kunesidingo salokhu kanye nesizathu sakho
 - b. Wakuthola kunjani ukufinyelela kuma-scale nasemagunjini okubelethela
 - c. Yiluphi usizo owalucela ngesikhathi ubeletha, isib. Utolika?
 - d. Yiluphi olunye usizo owaluthola?
 - e. Ngabe kukhona abakwenza khona ngaphandle kwemvume yakho? Uma kunjalo, chaza ukuthi bakwenzani futhi wazizwa unjani emva kwalokho?
 - f. Osuke wahlangabezana nakho uma ubelethela ezikhungweni ezibhekelele ukusiza ababelethayo kunamthelela muni empilweni yakho?
5. Ngabe zikhona izikhathi owake wafisa ukuthola usizo ezikhungweni ezibhekelele ukusiza abakhulelwe kodwa wagcina ukhethe ukungaluceli usizo? Kwaba yini isizathu esenza ungabe usalucela usizo?
6. Ngabe osake wahlangabezana nakho esikhungweni esibhekelele ukusiza abakhulelwe kunomthelela ngendlela obona ngayo ukusizwa nokunakekelwa kwabakhulelwe?
7. Ngokubona kwakho, yini engenziwa ezikhungweni ezibhekelele ukusiza abantu besifazane abakhubazeke njengawe ukuthi baluthole ngendlela efanele usizo?

Ngiyabonga ngokubamba kwakho iqhaza kulolu cwaningo

Appendix 10a: Questionnaire on demographic profile of healthcare workers

1. Age_____

2. Gender_____

3. Race_____

4. Years in practice as maternal healthcare service provider_____

5. Position:

Please tick (X) where appropriate.

Obstetrician	
Gynaecologist	
Midwife	

6. Employment status

Full time	
Part time	
Contract	

7. Have you provided maternal healthcare services to a woman with disability?

Yes	
No	

Appendix 10b: Focus group guide for maternal healthcare service providers

- a. Could you kindly share your experiences in providing maternal healthcare services to women with disabilities?
- b. What is your opinion with regard to the quality of maternal healthcare service you provide to women with disabilities?
- c. In the provision of maternal healthcare services to women with disabilities, what are the challenges that you face?
- d. What factors enable you as a healthcare worker to provide quality maternal healthcare services to women with disabilities?
- e. As maternal healthcare workers, are you comfortable with the provision of maternal healthcare services to women with disabilities? Please elaborate.

Appendix 11: Letter from the professional editor

EDITORIAL CERTIFICATE

Author: Doreen Mheta

Document title: A PRACTICE FRAMEWORK TO IMPROVE ACCESSIBILITY OF
MATERNAL HEALTHCARE SERVICES FOR WOMEN WITH DISABILITIES IN
KWAZULU-NATAL, SOUTH AFRICA

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This document certifies that the above manuscript was proofread and edited by
Mr G.S. Chinyani.

The document was edited for proper English language, grammar, punctuation, spelling and overall style. The editor endeavoured to ensure that the author's intended meaning was not altered during the review.

Kind regards

G. S. Chinyani

Mr Gilbert Chinyani (Cell: 078 609 3485)



Appendix 12: Turnitin report

Final submission

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