



UNIVERSITY OF GOTHENBURG
DEPARTMENT OF SOCIAL WORK

**“I give birth through my vagina
and not my legs”**

Ethiopian women with disabilities share their challenges in
access to sexual and reproductive health services

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Abstract

Title: “I give birth through my vagina and not my legs” - Ethiopian women with disabilities share their challenges in access to sexual and reproductive health services
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Keywords: women with disability, sexual and reproductive health, ethiopia, challenges in accessibility, focus groups

The research aim was to learn more of the actual experiences women with disabilities have of their access to sexual and reproductive health services. Another purpose was to contribute more to the current literature due to a lack of research regarding the women’s own perspective. The research questions were: (1) what kind of needs women with disabilities have related to sexual and reproductive rights and services, (2) what kind of challenges women with disabilities have or have had related to their access to sexual and reproductive health services, and (3) what are their thoughts about the reasons behind these challenges.

The research was conducted as focus group discussions in Addis Ababa, Ethiopia from June to July 2022. In total five focus groups were held. The participants either spoke the local language, Amharic, or sign language. Discussions were translated to English. The discussions were recorded and transcribed in English.

Five main challenges were identified and they were related to information, society, environment, finances, and support. The challenges were analyzed through a variety of concepts: availability, affordability, appropriateness, and assistance. The challenges were seen to be caused or exacerbated by the government’s exclusive policies and poor legislation, and the women’s internalized picture of themselves. These causing factors were analyzed through the concepts of accountability and approachability.

The results found indicate that the women face multiple overlapping challenges. The government of Ethiopia and other national, and international actors should address these challenges and take an active role in eradicating them.

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List of used abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality
Abilis	Abilis Foundation
ACHPR	The African Charter on Human and Peoples' Rights
AU	African Union
CEDAW	Convention on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of the Persons with Disabilities
EWDNA	Ethiopian Women with Disabilities National Association
FG	Focus group
ICF	International Classification of Functioning, Disability, and Health Model of Disability
I.E.	Inter alia
OPD	Organization of People with Disabilities
SRH	Sexual and reproductive health
UN	United Nation
WHO	World's Health Organization
WWD	Women with disabilities

1. Introduction

This research is about women with disabilities [WWD], and the challenges they have experienced in their access to sexual and reproductive health [SRH] services. The research process started when I contacted Abilis Foundation [Abilis] in autumn 2021 about cooperating for my master's thesis. We discussed our interests, and needs regarding SRH and disability research, and how to choose a topic that could benefit both parties. Abilis eventually suggested I contact the Ethiopian Women with Disabilities National Association [EWDNA], because they had wanted to do research about SRH rights among their members. EWDNA is one of the organizations of persons with disabilities [OPD's] which Abilis funds. Originally EWDNA had six different suggestions of possible SRH topics for me. I discussed them with my supervisor, and eventually chose the topic of challenges WWD face when accessing SRH services in the context of Addis Ababa, Ethiopia. I decided to address the research to persons who identify themselves as WWD. This choice was made to avoid incorrect or generalized gendering of the members of EWDNA.

In this research I used focus group [FG] discussions and individual, additional discussions which were conducted in Addis Ababa during June and July 2022. The research will be shared with both Abilis and EWDNA. The results and a short summary will be translated to Amharic and sent to EWDNA to be shared with their members, the research participants. The results of this research are of high value and relevance to both organizations i.e., as a background study for possible further research about SRH rights and services of WWD. Academic collaboration with OPDs helps the both-sided understanding of the lived experiences of people with disabilities, and maintains a vital critical lens which is needed to further research and advancement of disability rights (Norjanen et.al 2022,foreword). Also, Rohleder, Braathen and Carew (2019,p.95) suggest collaboration with OPDs, which are managed by people with disabilities so that people with disabilities can identify and define their own needs and design adequate services to meet those needs. Therefore this research can also shed some light on the SRH rights from a project funder's perspective.

1.1. Problem statement

The WHO (2011,p.81) states that compared to the general population, people with disabilities experience more health related issues, and their needs are more often ignored and unmet. The

topic of SRH rights, especially of WWD, is often a rarely discussed matter, difficult or embarrassing to talk about, or even a taboo in many countries (Abilis 2019,p.16; Rohleder et.al 2019,pre-words,p.44). WWD can thus be paid less attention to when it comes to the realization of human rights, such as SRH rights. This can lead to disinformation and misconceptions to any woman seeking for valid information, and to WWD being marginalized even further, which can create a feeling of powerlessness, and hinder them in forming sexual relationships (Abilis 2019,p.16; Rohleder et.al 2019,pre-words).

Additionally to often being a taboo, SRH rights of people with disabilities is also a neglected area of research (Rohleder et.al 2019,pp.2–3,89; Campbell Collaboration n.d.). Disability has been ignored in the sexual health research field, and vice versa (Rohleder et.al 2019,p.88). Also, Vergunst et.al (2015,p.1) highlight the lack of information regarding healthcare access of people with disabilities and mention how this kind of information is vital to improve their lives. The WHO (2011,pp.80–81) states how the lack of research can affect the possibilities of people with disabilities to seek for health services, i.e., due to the missing data of the policy- and decision-makers. The WHO (2011,pp.80–81) continues saying more research is needed with a focus on i.e., the quality and structure of healthcare systems, accommodations needed for people with disabilities in different services, the prevalence of people with disabilities, what services they use, and what kind of needs they have regarding their health care.

There also has to be more focus on the often overlooked SRH needs of persons with disabilities to ensure the realization of their human rights and to build a genuinely inclusive world (Beyene et.al 2019,p.102). According to Rohleder et.al (2019,p.89) most of the research conducted about disability is from higher-income countries, which has led to a skewed, even unknown, understanding of the lived experiences of the majority of people with disabilities, who infact live in low- and middle-income countries. Similarly to the WHO (2011,pp.80–81), Rohleder et.al (2019,p.4) also state that exclusion and barriers to inclusion are topics that urgently need addressing. These are reasons why the topic of this research continues to be relevant.

Though the Universal Declaration of Human Rights [UDHR], Convention on the Rights of Persons with Disabilities [CRPD], Convention on the Elimination of Discrimination Against Women [CEDAW], as well as the Convention on the Rights of the Child [CRC] are all protecting and ensuring SRH rights of people with disabilities, they are still globally

discriminated against (Abilis n.d.C.).¹ The still on-going Covid-19 pandemic, along with the wars, conflicts, natural disasters, or other humanitarian crises globally, as in Ethiopia, has increased the discrimination and neglect of people with disabilities, while simultaneously for the disability organizations it is, and has been more difficult to assist (WHO 2011,p.37; Rohleder et.al 2019,p.65; Abilis 2020,p.7). The pandemic, as other crises, has both created new challenges, and intensified the already existing ones for people with disabilities, which makes disability-related research even more relevant in the current times (WHO 2011,p.37; Norjanen et.al 2021,foreword). The WHO (2011,p.81) encourages all countries to work together to remove the barriers people with disabilities face when accessing healthcare services, by making the services more inclusive.

1.2. Purpose of research

This paper presents lived experiences and, specifically, challenges WWD have in their access to SRH services in Addis Ababa, Ethiopia. The topic for this research came from EWDNA - they wished to find out what kind of challenges their members have regarding their SRH rights. Therefore, this research contributes to that information gap, and aims to add knowledge and understanding about the challenges WWD have in realizing their SRH rights and accessing SRH services in Ethiopia.

To reach the purpose of this research WWD are heard through both FG, and individual discussions. The formulation of these discussions are based on the following research questions:

- (1.) What kind of needs WWD have related to SRH rights and services?
- (2.) What kind of challenges WWD have, or have had related to their access to SRH services?
- (3.) What are their thoughts on the reasons behind these challenges?

Additionally this research places the findings in a global perspective by presenting a literature review.

¹ On a societal level this can occur for example when having non-accessible SRH services – i.e., no ramps for wheelchairs, service only in one language, no signs, only online services, or narrow halls.

1.3. Relevance to social work and human rights

As mentioned above, the sexual health of people with disabilities is neglected, and a global concern. Rohleder et.al (2019,p.88) state that sexual health research has often been from a medical perspective with medical concerns in the focus. This suggests that other aspects of sexual health have not been researched, and are not of interests of researchers or funding actors, at least not to the same extent. We need to have more diverse research regarding perspectives, purposes, theories, and approaches to better include people with disabilities as whole, and respect their human rights. This lack of research violates their rights - they are ignored and not provided with access to adequate SRH services. This requires action from all levels of societies - macro, mezzo, and micro levels. Social work is an actor in all these three levels and therefore has a very important role in both disability, and SRH fields.

The disability movement, mostly led by OPDs, usually have both social work and human rights features in their work. One leading motto of the disability movement is “nothing about us, without us” which has a purpose of challenging the previously predominant way to conduct research on people with disabilities as objects rather than subjects (Rohleder et.al 2019,p.90). The motto highlights the participatory approach every research related to people with disabilities should have on all levels of research (imid.). The increased and diversified understanding of disabilities and SRH rights benefits people also outside of the disability community (Rohleder et.al 2019,p.89). This particular research, as other similar qualitative research, is needed, to increase understanding of the lived experiences of WWD, and to combine the results with other research to get a holistic view of the well-being and quality of life of WWD (WHO 2011, pp.46–47). This view of people’s lives is at the core of social work.

The topic of this research is not a new one, which does not mean, as explained before, that it would not be of relevance. The progress of gender equality and women’s empowerment has been rather slow and non-existent, especially in the global South (Asuagbor 2019). A reason for this could be that the methods, approaches, or topics studied cannot be implemented from the global North to the global South, or that the global South is mainly seen as a vulnerable, risky object of research (Rohleder et.al 2019,p.89). Instead, there should be more focus on developing research in, and from the global South. Especially from a social work perspective, we need to critically reflect on our ways to do social work. This research can benefit the future actors of the field, for example SRH service providers by gaining more data from the service users themselves

regarding what kind of accessibility challenges they might have. This research has an Ethiopian context but the data can also shed some light on the situations Ethiopians living abroad might be in, what they have experienced, or what their level of knowledge regarding SRH rights is. This kind of information is also needed when, or if migration further increases in the world due to globalization, global warming, wars, or such. A better understanding of these things can help social workers to better prepare themselves, and thus understand, face, and work with WWD. This research is also a reminder of the importance of accessibility for every person in all aspects of life, as part of the implementation and fulfillment of human rights [UDHR].

1.4. Scope of the report

The next chapter (2) is to present the two collaborating organizations.

Chapter 3 continues with background information about disability and SRH rights, and presents Ethiopia as the context of this research.

Chapter 4 sheds light on the previous literature on the topic - from Ethiopia and more globally.

Chapter 5 focuses on the theoretical and analytical concepts used in this research.

Chapter 6 presents the methodology - what was done and how it was conducted.

Chapter 7 brings us the results of this research. The results are analyzed by the use of the concepts mentioned in Chapter 5.

The reasons behind the results are presented and analyzed in Chapter 8.

Chapter 9 continues with providing ethical perspectives of the research.

Discussions about limitations of this research are found in Chapter 10.

And finally, Chapter 11 concludes the research.

2. Collaborating organizations

Here, the two collaborating organizations Abilis and EWDNA are presented in their own respective subchapters.

2.1. Abilis Foundation

Abilis Foundation is established and based in Helsinki, Finland. They were selected as a cooperative partner for this research for their work for people with disabilities, and our shared

interest in SRH rights of WWD. The foundation funds local grassroots OPDs' projects² about human rights, equal opportunities, participation, independent living, activities, education, and employment of people with different kinds of disabilities in developing countries (Abilis n.d.A.; Abilis n.d.D.). Abilis, in its work, is committed to follow the CRPD, while also using CEDAW, CRC, and the Sustainable Development Goals [SDGs] as central guiding tools, and principles in their work (Abilis 2019,p.5; Abilis 2020,pp.7–8). Abilis is also bound to, and steered by the policies of the Ministry for Foreign Affairs of Finland (Abilis 2019,p.6).

Additionally, Abilis uses participation, mutual solidarity, transparency, equality, and reliability as their ground values, and works towards a global implementation of these values (Abilis n.d.A.). Abilis (2019,p.12) considers it extremely important to support the employment of WWD, because they see it as a way for one to become independent by having an income, and gaining power. The foundation also wants to enhance and boost women's active participation, and thus gives special attention to projects that are focused on, led by, or otherwise benefit women, and/or girls with disabilities. (Abilis 2019,pp.22–24; Abilis n.d.A.; Abilis n.d.D.). Especially the SRH of WWD have raised concerns (Abilis 2019,p.14). The foundation aims to strengthen both the OPD's and their female members to improve and understand women's rights, to share awareness, and claim their rights in the society (Abilis 2019,pp.22–24). The participation of persons with disabilities empowers themselves and helps to change the negative attitude the societies have towards people with disabilities to more positive ones (Abilis n.d.D.; Abilis n.d.E.).

The funded projects must be organized, planned, implemented, and monitored by people with disabilities in local grassroots OPDs, which makes Abilis unique (Abilis n.d.A.). The foundation wants to support the agency of persons with disabilities to change their own lives and the society they live in (Norjanen et.al 2022,foreword). The organization sees equal opportunities as fundamental, yet, often people with disabilities are neglected in the realization of these opportunities (imid.).

Abilis (2019,p.9) states that WWD are often discriminated against even within OPDs, their own communities, which decreases their possibilities to participate. Abilis works hard to ensure women are heard, fully participated, and gain positions of power, and are not only used as

² During their 20 years of work, Abilis has funded more than 3000 disability-related projects, in over 80 countries across the global South (Norjanen et.al 2022,foreword).

“props” (Abilis 2019,p.24). A positive sense of oneself is vital in the process of empowerment, and thus they want to encourage WWD to reach their full potential by gaining a healthy self-esteem (Abilis 2019,p.20). The foundation highlights that providing peer support and role models, offering representation, from different aspects of life, can encourage the women to be more visible, independent, active, and to realize their potential and worth (Abilis 2019,pp.20,25). An example of this kind of peer support can be found also in the work of EWDNA.

2.2. Ethiopian Women with Disabilities National Association [EWDNA]

EWDNA, is a female-founded, female-led nonprofit OPD that promotes and advocates for an inclusive society for differently-abled women, and works to empower and build the women’s capacity, skills, and opportunities in life (EWDNA n.d.A.; EWDNA n.d.B.). EWDNA was founded in 2002 in Addis Ababa, Ethiopia, and has since expanded to have nine autonomous branch associations in six regions across Ethiopia (EWDNA n.d.B.). As mentioned previously, Abilis supports EWDNA’s work, and has two employees placed within the organization³.

Like Abilis, EWDNA highlights the vulnerable status of women, girls, and children with disabilities. EWDNA targets women and girls who have either an intellectual or physical disability, have been affected with leprosy⁴, have a sight or hearing impairment or are blind and/or deaf (EWDNA n.d.A.). The board of the association also represents various disabilities (EWDNA n.d.B.). Fikirte Shumet, a Project Coordinator of EWDNA, explained that women who have leprosy face the highest marginalization in Addis Ababa, because people think leprosy is transmissible, and thus do not want to be in any contact with them. She stated that it is the ones who are the most marginalized that are given the priority by EWDNA (Shumet, personal communication, July-2022).

The association encourages WWD to advocate, promote, and exercise their human rights in their societies (EWDNA n.d.B.). Some of the projects and activities they organize, have provided their members psychosocial support such as social events or meetings with peers, home visits, and interpreters. They have also educated their members about existing laws and rights, promoted inclusion and self-reliance, helped members to connect with other actors, as well as

³ The two employees at EWDNA’s office in Addis Ababa are Martha Belayneh and Afomia Debebe.

⁴ According to the WHO (2022) leprosy is a chronic infectious disease that affects mainly one’s skin, the peripheral nerves, mucosa of the upper respiratory tract, and the eyes. It is curable with multidrug therapy, and treatment in the early stages can prevent disability.

developed educational training (EWDNA n.d.C.). EWDNA arranges coffee ceremonies in their outdoor premises every other Thursday to bring their members together and discuss their experiences - sometimes as different workshops. The element of training or workshops, might strengthen the empowerment of the WWD, due to the possibility of them meeting, giving, and receiving peer support while learning - which are some core components to empowerment (Abilis 2019,pp.20,26). Also the WHO (2011,p.156) mentions that gathering people with similar experiences may be useful in the aim of supporting not only individuals with disabilities, but their families as well.

The WHO (2011,pp.143-144) recognises possible limits small NGOs, especially in low-income settings have: small facilities and resources, thus limited reach, though their expertise and advantages can be comprehensive with plenty of good, innovative, specialized practices. Shumet commented that the work they do, and the capacity they have is very little, while the demand in the city is very extended (personal communication, July-2022). EWDNA's office is small, and the outdoor grounds are too tiny to be accessible and comfortable for their members. EWDNA's work is both additional and complementary to the local welfare and health services (Shumet, personal communication, July-2022).

3. Background

To have a better understanding of the research topic, it is necessary to explain how disability is defined, what the disability and SRH rights are, especially in the context of Ethiopia.

3.1. Definitions of disability

Rohleder et.al (2019,p.10) ask, what do we understand by the term 'disability', and explain that it might not be as straightforward as it first seems. According to the authors (p.10), what disability means depends strongly in which context it lies, and from what perspective it is viewed from.

“Is a person who makes use of a wheelchair “disabled” because he or she makes use of a wheelchair in and of itself, or are they disabled because they face stairs that prevent them from accessing a space? Is a person who is blind “disabled” because they cannot see, or are they disabled because they cannot access written information?” (Rohleder et.al 2019,p.10)

The CRPD defines a person with disabilities as people 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.” (Art.1§2). Similarly to the CRPD, the WHO (2011,p.3; 2017) defines disability to refer to a multidimensional interaction between individuals with a health condition, and personal and environmental factors. Disability is often associated with varying types of health conditions, but having a health condition does not mean per se, that one also has a disability or is of poor health - it depends how the condition interacts with other factors (WHO 2011,pp.32,57–58). Disability can be understood as a complex spectrum that varies from minor to major difficulties, with their own impacts on an individuals’ life, relating to other factors such as age, environment, sex/gender, culture and stage of life (WHO 2011,pp.3,22,44). Neither of the above definitions specify the length that is considered or ‘required’ for a disability. What both the definitions, as well as some disability researchers’ definitions have in common, is that they present disability as both an individual and a societal construction: a fluid definition changing by the context of who, and from which it is viewed and defined, since a person’s surrounding environment has a considerable impact on the prevalence and extent of the disability, and how it is experienced (WHO 2011,p.44; Withers 2012,pp.2–4,6).

Though these definitions are quite widely approved and understood, Rohleder et.al (2019,p.10) state that there is no universal understanding on the cause of disability, and present possible alternatives: a medical condition, a biological impairment, god’s will, karma, spell, or social and environmental barriers. From supernatural, divine, spiritual, or religious explanatory perspectives, disability can also be cured by a “divine intervention” (Rohleder et.al 2019,p.11). They (p.31) also state that disability is strongly culturally constructed, and provide an example of a person with albinism, who probably is not seen as disabled in a ‘Western’ context as they may be in an African context. Withers (2012,p.108) claims that the definition of disability depends on and shifts according to those who are in power, and how they consider disability, normality and abnormality.

Withers (2012,pp.2–4,6) says that although the definition of disability has changed in time, and is different depending on the context, there is an underlying part that rises from outside of the

norm⁵, which too, is bound to its context. They (2012,p.2) claim that one cannot truly understand where disability currently is, without understanding where it has been before. In their book, Withers (2012) presents different models of disability, which are also shown in the Fig.1 below. Withers (2012,pp.3,6) explains that these models have through times and cultures been used to understand and explain disability, and that the concept has altered through them (see also WHO 2001,p.20). The models can occur on their own, but very likely also simultaneously, merging and strengthening each other (Withers 2012,p.3).

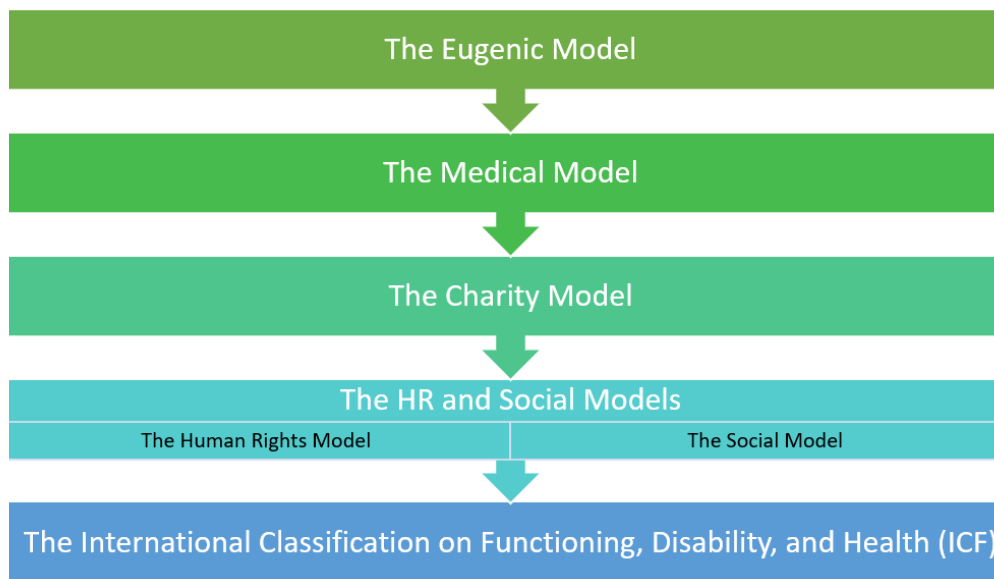


Fig.1 Different models of disability presented in a generalized chronological appearance.

Withers (2012,pp.3–4) states that the first, modern day classification of disability was created by eugenics, which till this day affects enormously our way of seeing and understanding disability. Eugenics targeted people with socially or genetically considered unwanted, negative and inheritable characteristics, and who were struggling, often from existing social injustices (pp.4,6,14–16). This legitimized “othering”: stigmatizing, devaluing, and suppressing certain groups of people in the society (p.16). Withers (2012,p.28,50) claims that even nowadays, if a pregnancy is intervened to prevent disability, eugenics is present.⁶

⁵ According to Withers (2012,p.6) the norm, or the ideal, at least in the Western societies, is white, straight, productive, profitable, and patriarchal people - and the disabled people challenge this ideal.

⁶ I.e.,when someone is sterilized, gets birth control against their will or knowledge, receives genetic counseling, has different tests operated on the pregnant person to find out possible deficiencies of the yet unborn child, or when there is social pressure, or public shaming upon WWD not to have children (Withers 2012,pp.28,50).

The medical model follows the eugenic model and considers disability as a biological or psychological, abnormal impairment, an individual medical problem that could be diagnosed, cured, or 'fixed' (Withers 2012,pp.4,31; Rohleder et.al 2019,pp.4,12). The WHO (2001,p.20) adds that the model sees disability as caused by a health condition, trauma, or disease. The model has dominated the understanding of disability in mainstream society after eugenics, and partly continues their legacy due to its roots in the eugenic movement (Withers 2012,pp.4,31,54). Withers (2012,p.47) points out that within this model it is often overlooked that some people with disabilities do not want to be changed or cured. Many people with disabilities have seen the model as an oppressive force and are fighting to have it dismissed - by replacing it with a model more focused on social justice (p.54-55).

Withers (2012,pp.4,58) presents the charity model as an addition to the medical model with a softer moral angle by representing persons with disabilities as innocent victims suffering from tragic disabilities. The charity model places a good deal of focus on the giver, instead of the receiver, in this case, the people with disabilities (pp.58,65). The model has its roots in the Christian idea of helping others, and claiming salvation from it which has been formulated in charity (pp.57,61). Fundraising for people with disabilities, organized by the actors within this model, can be in forms of donating clothes or other goods, but can lack the perspective of their actual needs, rights, and capabilities. Withers (2012,pp.59,72) argues that the gathered funds are often directed to research and the prevention of certain disabilities, thus prevention of people with disabilities. A major part of donations are from corporations, many from "telethons"⁷ (pp.61-62). Withers (2012,pp.78-79) implies that the model paints a picture of an oppressive approach: infantilizing and reinforcing stereotypes of people with disabilities. They (p.79) does clarify that eradicating the charity organizations would not solve the problem - on the contrary, it could remove the only support some have to rely on.

The human rights model rose as a response to the medical model (Withers 2012,pp.5,81). It focuses on the idea that people with disabilities have equal access to the same privileges, and human rights as people without disabilities (pp.81,85). The model considers disability as an individual characteristic that a person is discriminated against and unequally treated for in their surrounding societies (p.81). Thus, at the core of it is the call for inclusion of people with

⁷ Television shows, with a variety of different performances, sharing tragic (disability) stories, and asking for donations by using vivid visual and audio material in an attempt of raising people's emotions and willingness to help (pp.61-62)

disabilities to take control of their own lives and fates, since participation is seen as a universal human right. The social model was also created as a response to the medical model (Withers 2012,p.5; Rohleder et.al 2019,p.13). This model has expanded to influence people with and without disabilities globally (Withers 2012,pp.5,86). The model sees disability as a social construction, a complex collection of different conditions, many created by the social environment (WHO 2001,p.20). Its perspective is that society is to be changed to fit people with disabilities, not the other way around (Withers 2012,p.5; Rohleder et.al 2019,p.93; Mesiäislehto et.al 2022,p.37).

The last two models were developed from and inspired by other civil rights organisations, social actions, and feminist movements, and have made multiple long-lasting changes and improvements for the disability movement (Withers 2012,pp.5–6,82,90). The new way of understanding disability provided people with disabilities a community of their own, to unite against the oppressive social structures, and to see themselves as individuals, part of the society and the world (Withers 2012, pp.87–88,97). This new understanding of oneself: my differences or impairments are okay, but the way I am treated is not, can have been revolutionary for some people with disabilities.

Lastly, the WHO (2001) established a new kind of way to understand and define disability: the International Classification of Functioning, Disability, and Health (ICF). The ICF defines both functioning and disability as umbrella terms - functioning consisting of bodily functions, activities, and participation, while disability meaning the impairments, limitations and restrictions in activities and participation (WHO 2001,p.3). This model is currently the prevailing model of disability globally, and is based on the previous medical, human rights, and social models (WHO 2001,p.20), establishing a focus on individual needs rather than on the disease, impairment, or other condition (Aluas et.al 2012,p.146). According to the WHO (2001,pp.19–20), the ICF tries to accomplish a coherent classification: various views of health by merging and combining biological, individual, as well as social perspectives, which is important, due to the fact that people having the same diagnosis might have completely different levels of functioning, and people with the same level of functioning might not have the same diagnosis or health condition (see also WHO 2011,pp.21–22). Although, the ICF does not take socioeconomic factors, such as one's gender, race, lifestyle, education, coping styles, upbringing, or religion into account, since they are not considered as health-related circumstances (WHO 2001,pp.7,17).

3.2. Prevalence of disability

Currently, over a billion people, approximately 15 percent in the world, live with some sort of disability, and the number is increasing due to i.e., chronic health conditions, aging, and demographic trends (WHO 2021). Almost 80 percent of people with disabilities live in lower income countries (WHO 2011,p.28; Kassa et.al 2014,p.583). The WHO (2011,p.28) estimates that there are globally fewer men with disabilities than WWD.

It is important to note that anyone could end up having or living with a disability - i.e., some disabilities can occur due to genetics, age, or medical conditions, and some are results of accidents or injuries. The WHO (2011,p.3; 2021) states that almost every person is likely to experience some sort of temporary or permanent disability at some point of their lives. Some might have intense pain, while others have mild, and some might be severely restricted, while others barely face any restrictions in their daily lives - even if their disability types are the same (WHO 2011,p.22; Rohleder et.al 2019,pp.4–5). It is also vital to understand that not all people who have or live with disabilities or impairments consider or identify themselves as disabled⁸ (WHO 2011,p.24). Swartz (2014,p.4) points out that most people would likely rather say they have difficulties in certain aspects of their lives, i.e., mobility, sensory skills, social participation, or self-care.

3.3. Disability rights

Disability is strongly connected to human rights issues, because people with disabilities are often being subjected to rights violations - they are prone and at greater risk to violence, abuse, disrespect, and prejudice due to their disability (WHO 2011,p.59; WHO 2021). People with disabilities might also face multiple discrimination if other individual features or identities such as sex or gender, age, socio-economic status, or sexuality intersect with their disability identity (Rohleder et.al 2019,p.30; WHO 2021). Even if the discrimination would not be intended on a personal level, the society's systems often indirectly exclude people with disabilities by not taking their needs into account in the first place (WHO 2011,p.6). Rohleder et.al (2019,p.5) highlight that similarly to every other person, people with disabilities have a variety of unique and individual characteristics that affect their capabilities to encounter different challenges in life.

⁸ I.e., older persons whose decreasing abilities in functioning are related and appropriate to their age (WHO 2011,p.24)

The United Nations [UN] has clarified and separately stated the rights of persons with disabilities in the CRPD, which works as a guiding tool to promote, protect, and advance the recognition of human rights of people with disabilities, and to fight against discrimination (WHO 2020). These rights have been stated by the UN Economic and Social Council [ECOSOC] already in 1994 in the Standard Rules for the Equalization of Opportunities for Persons with Disabilities. The rules include components of i.e., accessibility, medical care, family life, policy-making, OPDs, support services, and awareness-raising. WWD have been given an entire article in the CRPD (Art.6), because they can face challenges more diverse and unique compared to other people with disabilities⁹.

3.4. Sexual and reproductive health [SRH] rights

SRH, including the respective rights, is a very wide concept, that can cover themes such as sexuality; sexual orientation; sexual behaviour, expression, and pleasure; sexual health and education; safe sex; gender identity; prevention and treatment of STDs and gender-based violence; relationships; menstruation; (in)fertility; contraceptives; abortion or (unintended) pregnancy; breastfeeding; parenthood; physical and mental health care; medication; health-related rehabilitation; public health programmes and hygiene. It is important that these are seen and understood within each current local social, economic, and political contexts. (WHO 2011,p.61; Rohleder et.al 2019,p.41; WHO n.d.B.)

SRH rights are mentioned in the UDHR, CRPD, CEDAW, as well as in the CRC. Human rights apply to everyone everywhere equally without discrimination: they are universal, interdependent, and indivisible (UDHR; WHO 2017). Unfortunately, this is not always the case in practice. People's age, living and working environment, conditions they are born into, grow, or currently live in, poverty, and other circumstances, contribute to the possible risks of their overall level, and situation of health (Rohleder et.al 2019,p.31). The right to health includes both freedoms, such as the right to control your own body without interference, torture, force, or non-consensual medical treatment or experimentation, and entitlements, such as the right to healthcare protection (WHO 2017). If human rights, such as SRH rights, are violated or not given enough attention to, it can result in significant health related consequences (imid.).

⁹ Rohleder et.al (2019,p.26) say that disability can, in addition to sex and gender, also intersect with the society's predominant understanding of what it means or takes to be a woman: gender roles and norms, as well as general assumptions on one's gender.

People with disabilities have an increased risk of being exposed to forced treatment, coercion, and other kinds of human rights abuses (WHO 2017), as well as to social isolation and exclusion due to the stigma they face of disability and sexuality (Rohleder et.al 2019,p.29). The risk of sexual abuse is very high for WWD, and can vary by the disability or impairment a woman has, i.e., a woman with a physical impairment might be sexually harassed when carried around, or a woman with an intellectual impairment might be abused because of her difficulty of understanding, and reporting of it - therefore it is important to acknowledge that the abuser can be whoever and wherever (Abilis 2019,p.19; Rohleder et.al 2019,p.54). According to Rohleder et.al (2019,pp.55,64) in some cultures, WWD can be used for “virgin cleansing”, which often happens in form of a raping a virgin, which is thought to cure a person with a STD (Rohleder et.al 2019,pp.4,23). Since many WWD are considered as asexual, some people can also assume them as virgins. Obviously WWD in general contract STDs in similar ways to women without disabilities (Rohleder et.al 2019,p.42,73). Due to the above-mentioned practices, WWD have even a higher risk of getting STDs (Abilis 2019,p.16).

Assumptions of people with disabilities, as asexual, non-sexual, violent or sexually dangerous, or not in need of sexual education, tend to be more common for people with physical, psychosocial, and intellectual disabilities - they are considered as having no sexual needs, or physiologically unable to have sex (Rohleder et.al 2019,pp.4,23) As Beyene et.al (2019,p.102) point out, a person’s disability does not affect their fertility per se. Fighting against generalised and derogatory assumptions like these does not mean that people with disabilities could not identify themselves as i.e., asexual. In general, people with and without disabilities have the same sexual needs and desires (Rohleder et.al 2019,p.25). Despite one’s sexual orientation or disability, everyone has the same SRH rights and thus, should have access to i.e., sexual education. Sexual health is fundamental for people’s overall health and wellbeing¹⁰ (WHO n.d.B.). For people with disabilities to receive the same opportunities to accurate and adequate sexual health education, the assumptions people without disabilities have of disability and sexuality, should be changed (Rohleder et.al 2019,p.41). Often the sexual health education is provided from a non-disabled, heteronormative perspective - one which may not benefit all people with disabilities (Rohleder et.al 2019,pp.32,43). Thus, it is vital to provide SRH care and education to all people.

¹⁰ According to the WHO (n.d.B.) it thus requires a respectful and positive approach to sexuality, sexual relationships, pleasure, knowledge about risks and safe sexual experiences, freedom of discrimination, violence, or coercion, access to comprehensive and quality information related to sexual health as well as sexual health care services.

3.5. Ethiopia - the country of operation

Federal Democratic Republic of Ethiopia is an East-African country located in the northeast of Africa¹¹ (Government of Ethiopia n.d.C.). Ethiopia is a country that consists of more than 80 different languages, ethnic groups and nationalities (Government of Ethiopia n.d.D.). The capital city is Addis Ababa (Government of Ethiopia n.d.B.), the city where this research also took place. Ethiopia is classified as both a low-income country by the World Bank (2022) and as one of the least developed countries by the UNCTAD (2021). It is also listed as one of the countries located in the global South (FCSSC n.d.)

The estimations of the total population of Ethiopia has varied from 74 million (National Population and Housing Census [NPHC] 2007,p.7), to 89-90 million (CSA 2014) and to the current estimation of 100-118 million people (The World Bank 2021; Government of Ethiopia n.d.A.). Similarly the population estimates of Addis Ababa have varied from 2,74 million (NPHC 2007,pp.18), to 3,8 million citizens (Population Projection Wereda Census 2021,p.38). This increase in the city's population does not seem to follow the same growth as the country's total population. Shumet herself estimated the total population of Addis Ababa to be closer to 10 million (personal communication, July-2022).

The prevalence of people with disabilities in Ethiopia has been calculated differently during the years, and therefore it is difficult to give precise figures. As mentioned previously, the WHO (2011,p.28) estimates that people with disabilities cover 15 percent of a country's total population. Calculating this from the NPHC's (2007) total population estimations, gives us roughly 11 million people with disabilities. This number does not go with the respective Census' (2007,p.134) estimation which is slightly less than 806 000 people. It can be assumed that the current, actual figures are significantly higher than this. In the NPHC (2007,p.129), a person with disability was classified as someone who cannot carry out activities others can, due to congenital, or long-term physical or mental disabilities. The following ones were listed as different types of disabilities; blind, seeing difficulty, deaf, hearing difficulty, dumb, speaking difficulty, deaf mute, disability in hands, disability in legs, physical organs movement difficulty, mental retardation, mental problem, and other (2007,pp.129–131).

¹¹ The area is also called the Horn of Africa. Ethiopia has neighbouring countries of North Sudan, South Sudan, Eritrea, Djibouti, Somalia, and Kenya (Government of Ethiopia n.d.C.).

Kassa et.al (2014,p.583) have stated that there is no recent disability survey on a national level in Ethiopia (see also Katsui et.al 2014,p.42), and still the NPHC (2007) seems to be the latest one, which makes it hard to find up-to-date data about the disability prevalence in the country, let alone of the prevalence of WWD in Ethiopia. The lack of precise figures on disability prevalence makes it more difficult to create and enhance disability policies and programmes, to ease and remove disabling challenges, and to increase accessible services for people with disabilities (WHO 2011,p.11). What can be said is that disabilities occur at a higher prevalence in lower-income than higher-income countries because disabilities and low income often strengthen, increase, and maintain each other (Nguyen 2020,p.371; WHO 2021). Also EWDNA (n.d.C.) states that the higher rates occur due to i.e., poverty, lack of understanding, and resources in healthcare.

The Constitution of Ethiopia (1995) prohibits discrimination (Art.25) on the grounds of “[...]race, nation, nationality, or other social origin, colour, sex, language, religion, political or other opinion, property, birth or other status”. Disability is not mentioned in this context. In fact, there is only one reference to disability or a person with a disability in the Convention:

“The State shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardian.” (The Constitution of Ethiopia 1995, Art.4§5)

Shumet (personal communication, July-2022) stated that the above-mentioned clause leaves room for the service providers to interpret it to their benefit. She says inclusive education is mentioned in the employment policy, but that this article is used in an integrative way rather than an inclusive one. Nevertheless, Shumet considers these articles still as tools to fight for accessibility and inclusion (personal communication, July-2022).

The African Charter on Human and Peoples' Rights [ACHPR] (1981), which Ethiopia has ratified, states that all people should be equal, with the same rights and respect, but by now, we are aware that this is not always the case in practice. Likewise the UN, the African Union [AU] also has separate human rights legislation regarding women, and people with disabilities. The Protocol to the ACHPR on the Rights of Women in Africa (the Maputo Protocol 2005) is the main legal instrument for the protection of the rights of women and girls in Africa (AU 2014). It includes women’s rights to a respected and promoted SRH, and the state’s role to take all

appropriate measures in providing adequate, affordable, and accessible health services. According to the AU (2022), Ethiopia has not ratified the Protocol to the ACHPR on the Rights of Persons with Disabilities in Africa (2018). The lack of realization and implementation of proper policies and human rights legislations places Ethiopian WWD in a grave risk of neglect, ignorance, abuse, and other human rights violations. The government's and other actors' actions are not aligned with the extent of challenges people with disabilities face in Ethiopia (Katsui et.al 2014,p.39).

In Ethiopia, WWD are particularly vulnerable regarding their SRH rights because of multiple reasons. For example, Rohleder et.al (2019,p.39) state that in the context of low-income countries, men with disabilities are less disadvantaged than WWD. Women might experience negligence regarding their sexuality or sexual life by the surrounding society, or common beliefs, such as having a non-existing or a limited sexual life, not having sexual requirements, or not being able to experience sexuality or carry children (Aslan et.al 2021,p.596). As these can be true to some WWD, they cannot be generalized to cover them all. EWDNA (n.d.C.) states that in Ethiopia, particularly the different traditional beliefs and practices are hindering WWD of getting education, information, or having any social relations. Some WWD might experience multiple difficulties in their sexual lives due to their existing impairments, or limitations, disliking their own physical appearances, treatments or medication, pain, low self-esteem or sexual satisfaction, the lack of possible meeting places for partners, fear, or negative attitude of others (Aslan et.al 2021,p.596).

As mentioned, regarding family life, relationships, or having children, WWD are often considered as incapable or not worthy of achieving these. According to Abilis (2019,p.8) there is for example a belief that if a WWD is pregnant, the child will also have disabilities. An option for discouraging WWD from having children is to not even mention the possibility of it. In a variety of cultures, women are appraised by their capability of motherhood - which can determine their status in the society (Abilis 2019,p.15). This is obviously a barrier for WWD who, from the beginning, are often excluded from the possibility of becoming a parent. These different kinds of assumptions about disability and sexuality could also eventually be internalized by people with disabilities themselves and decrease their participation in the society, as well as their attempts to claim their SRH rights.

WWD might also experience i.e., difficulties in expressing their sexualities, or sexual wellbeing in ways that are satisfying for themselves and yet similarly appropriate in the eyes of others (Kassa et.al 2014,p.583). Abilis (2019,p.8) notes that denying WWD from performing their gender or self-expression maintains the idea that they only need the bare minimum, and are not entitled to the full human experience (see also WHO 2011,p.78). These aspects can be intensified for women who are members of the marginalized LGBTIQ+, ethnic, religious, or racial groups or communities. According to representatives of EWDNA, and my assistant, the LGBTIQ+ movement in Ethiopia is basically non-existent due to the strong stigma, illegality, and cultural norms present in the country.

3.6. To conclude: women with disabilities and their SRH rights

WWD have the same rights to their sexual and reproductive lives as well as to their general health, as women without disabilities (Aslan et.al 2021,p.596). That said, many women are excluded of the possibility of having and enjoying the right to health due to i.e., disadvantage or disability, marginalization, (un)employment, education, language, migration status, gender identity or sex, sexual orientation, or ethnicity. Sometimes women can be simultaneously excluded on the grounds of multiple individual features, which increases and exacerbates inequalities and inequity (WHO 2017).

WWD might often need different, sometimes rather costly healthcare services to help them survive and live their lives, to have their basic human needs and rights met, and if they are being discriminated against due to this, they can face an increased risk of multiple human rights violations (WHO 2011,p.40; WHO 2017; Rohleder et.al 2019,p.60). Nevertheless, if some people with disabilities do not need complex or extensive healthcare needs due to their impairments, some might (WHO 2011,pp.40,59; WHO 2021). The reality is though that only few countries provide adequate healthcare services for people with disabilities (WHO 2021). There needs to be more attention to WWD and SRH rights in Ethiopia, but just as much in the global perspective.

Though the challenges many WWD have accessing SRH services are extensive, especially in low-income countries, Rohleder et.al (2019,p.85) claims that they should not be seen as insurmountable. Likewise WHO (2011,p.12) states that WWD can benefit from development

projects, and especially in low-income countries their situation can in fact be improved - if disability is given a higher priority and a more coherent response is carried out.

4. Literature review

As previously mentioned, although SRH of WWD is often considered a rarely studied matter, it is not a new one. There are numerous OPDs, and several related studies globally. Some of these studies are presented below.

4.1. Literature search

I started the literature review by searching keywords in the Gothenburg Library search engine, as well as on Scopus, Sage Journals, Google Scholar, and ProQuest Databases. I used words such as disability, Ethiopia, sexual and reproductive health rights, women/persons with disabilities, disabled sexuality, Ethiopian women with disabilities, reproductive rights, health rights, and disability and sexual health. The suggested results, as well as the reference lists that came along with the articles I found also proved to be useful in finding more relevant and interesting material.

During the spring 2022, I took part in two disability-related online courses¹², which also provided me with important insights and information for this research, as well as some good resources that I have used. Additionally I read reports from the WHO, and other materials I had received from both EWDNA and Abilis.

4.2. Previous literature on SRH and disability

To give a proper context to this study, it is important to present previous literature not only from a global perspective but also from an Ethiopian perspective. Rohleder et.al (2019,p.35) argue that there is a paradox in how very little knowledge and understanding we have of the sexual lives of the majority of people with disabilities, due to a literature gap regarding low-income countries. Chappell (2019,p.2) similarly claims that this imbalance can be a result of the dominance of resources and power the global North has over, and compared to the global South.

¹² Global Disability: Research and Evidence, and Global Health and Disability by London School of Hygiene and Tropical Medicine.

Rohleder et.al (2019,p.28) claims that multiple research has been conducted with a focus on physical disability and sexual function, and fewer on disability and one's sense as a sexual being, though according to Chappell (2019,p.1) the focus has shifted towards recognising the multiple intersections influencing both disability and sexuality. Rohleder et.al (2019,pp.33–34) also point out the major gap of research regarding the intersection of people with disabilities who also identify themselves as LGBTIQ+, a topic that is a relatively neglected area of both disability and sexuality studies¹³.

4.2.1. Globally

As mentioned earlier, the topic of SRH rights and disability is often a taboo, but there has been several recent, related studies from more wider perspectives (Nguyen 2020; Matin et.al 2021), and more country-specifically from i.e., Columbia (Padilla-Muñoz 2019), United Kingdom (Clarke and McKay 2014), Indonesia (Suriyani et.al 2020), India (Ghosh 2019), and Jamaica (Bartley 2019). Though these studies are somewhat recent, some date back to the early 2000's (Fiduccia 2000; Christian et.al 2002; Dotson et.al 2003; Earle and Church 2004).

Disability and SRH rights have increased the attention of students of a variety of fields. This has been a topic for many master's students, like myself, as well as doctoral students around the world. For example, Azzopardi-Lane and Callus (2016) present their study of WWD regarding their experiences of parenthood in Malta in a student and graduate led journal. Their study claims that the women, with their stories, confronted the stereotypes of WWD and it is in fact the society that lags behind upholding misconceptions and false perceptions of WWD as incapable of being parents (p.31).

Some research have specific parts of SRH rights or services that they focus on, such as abortion, pregnancy, other gynaecological matters, menstruation, romantic relationships, or sexuality of women or girls with disabilities (Campbell 2017; Adhikari 2018; Petal and Lieketseng 2019). Some however have focused on a certain form of a disability and SRH rights (Kandel et.al 2005; Kramers-Olen 2016; Verlenden et.al 2019).

The found literature was qualitative, quantitative, as well as mixed-methods research in forms of literature reviews, FGs, or questionnaires about staff's, other professionals', or even people

¹³ Some LGBTIQ+ and disability related research have been conducted in recent years i.e., in South Africa (Msekele 2019).

without disabilities' views on SRH rights of people with disabilities (Cuskelly and Gilmore 2007; Lee et.al 2015; Chouinard 2015; Hamilton 2015; Hunt et al. 2017; Devkota et.al 2017; Louw 2019). Few had a social work or a social worker's experience or perspective on the matter (Christian et.al 2002; Adams Rueda et.al 2017).

For example Wickström, Larsson and Höglund (2020) made FG interviews with staff that work with youth with intellectual disabilities, about how SRH and these rights can be enhanced among their clients in Sweden. Their research showed that the staff had experiences of powerlessness, and difficulty of balancing support, safety, and privacy, not to mention the dilemma of the rights of the parents vs. the youths, and the obligations of the staff vs. parents (pp.4–8). The staff also lacked knowledge about SRH rights, the skills to teach about them, and proper guidelines (p.5). The respondents also mentioned that often the services are not meeting the needs of the youth with intellectual disabilities (p.6).

Of the total research found, only few had people with disabilities as their participants or interviewees (Dotson et.al 2003; Aslan et.al 2021). Aslan, Yilmaz and Acar (2021) as an example did a research in Turkey to find out about the reproductive health, sexual function, and satisfaction levels of women with physical, hearing, and visual disabilities. Their research found out that about 81 percent of their participants had basic knowledge about sexuality (p.599). The majority of them had received the information from the media and their own friends. Only about 15 percent reported receiving information about sexuality from school (pp.599–600).

According to a systematic review in qualitative studies conducted by Matin et.al (2021,p.2) WWD are more likely to have unmet healthcare needs, and more often excluded from sexual education programmes, compared to women without disabilities. They (imid.) also say that a certain type of disability might have an effect on how WWD access SRH services. They mention approachability, acceptability, availability, affordability, and appropriateness, as dimensions of the challenges WWD might face while accessing SRH services (pp.5–19).

Like Matin et.al (2021), Nguyen (2020) conducted a scoping review on qualitative studies on the challenges women with physical disabilities have accessing reproductive health care around the world. Many studies named stigma, discrimination, non-accessibility of facilities and services, family influences, and limited SRH rights related inclusive education as some of the biggest barriers for the women in both low- and high-income countries (pp.378–380,383,388). The

barriers were presented in four different categories: social, physical and geographical, income, and educational (p.383).

Not previous literature per se, but the availability, accessibility, acceptability, (accountability,) and quality (AAAQ) framework by the WHO, has been referred to in other research. The framework is used to assess challenges to healthcare (WHO n.d.A). The WHO considers that the AAAQ principles are all interrelated elements that are required to be fulfilled in the matter of the right to health (WHO n.d.A.). Somewhat similar to the AAAQ principles, Katsui and Mesiäislehto (2022,pp.196–198) suggest their own, more specific, 6 A's: availability, affordability, accessibility, accountability, assistance, and affection - to implement embodied equality in practice.

4.2.2. In Ethiopia

There has been a magnitude of research conducted in the African context, regarding SRH rights and disability. Swartz (2014,p.1) claims that disability research, especially in sub-Saharan Africa, has developed fast. A fair share of this research has been conducted in South Africa (Moodley and Ross 2015; Vergunst et.al 2015; Vergunst et.al 2017), where Swartz also comes from, but several other studies are available from Ghana (Mprah 2013), Senegal (Burke et.al 2017), and Nigeria (Abubakar and Dukku 2020).

To mention one very recent study, Mesiäislehto et.al (2022,p.41) studied menstrual pain experiences of WWD in Tanzania. Their study revealed that young WWD are neglected, and the level of neglect depends, i.e., on the woman's disability type and severity, financial status, and living surroundings. They also found out that the women were neglected by health care professionals who often ignored their rights and needs (imid.).

Although there is a magnitude of this literature in an African context, it was a challenge at first to find literature that relates to WWD and their SRH rights or services in Ethiopia. This also confirms the notion of Addis and Mesele (2020,p.10), that the scope of research is limited when it comes to WWD in an Ethiopian context (see also Boersma et.al 2019,p.167; Mesfin Yesgat et.al 2019,p.4). Addis and Mesele (2020,p.15) further claim that without knowing the reasons of challenges WWD face, there will be no progress in generalizing the connections between gender and disability. According to Kassa et.al (2014,p.583) the currently existing research does not really focus on people with disabilities in relation to SRH rights and services in Ethiopia. They

too claim that it would be beneficial to recognize the status, challenges, and the possible gaps in the knowledge and the understanding about SRH rights of people with disabilities, to truly be able to target the problems with appropriate policies and strategies (imid.).

Addis and Mesele (2020) studied challenges and coping strategies of married women with physical disabilities in Ethiopia, and revealed a variety of challenges reproductive and health problems were part of. Challenges mentioned were socio-cultural, domestic, psychological, economic, as well as gender- and disability-based violence (pp.12–14). All these challenges have elements related to SRH rights. For example, in their study, married WWD were often denied access to basic healthcare services such as screenings and medication (p.14).

Beyene et.al (2019) studied modern contraceptives and possible problems WWD have using those in Gondar City, Ethiopia. Their questionnaire results showed multiple factors that were associated with the women's use of contraceptives, such as their age, marital status, disability type, work, education, and religion (p.104). Also, Mesfin Yesgat et.al (2019) studied WWD and family planning - their focus was in the use of the respective services in Southern Ethiopia. Their results showed that more than 30 percent of the WWD in reproductive age used some kind of family planning - i.e., work and marital status were associated with how and if the services were used (p.10).

Another similar study is about barriers in accessing pharmacy services for people with visual, physical, or hearing disabilities in Addis Ababa by Dagnachew, Meshesha and Mekonen (2021). Their outcomes were that the services are not accessible for people with disabilities, and that the barriers were higher for people with disabilities than for people without disabilities (pp.3,6). The study presented six major barriers: transportation, physical, communication, strategies for professionals to alleviate communication barriers, price of medicine, and participants' perceived perception of the services (pp.3–6).

Two earlier research (Kassa et.al. 2014; Kassa et.al 2016) that I found on SRH rights, and the access to SRH services among people with disabilities in Ethiopia have been conducted in 2012. Kassa et.al (2014) studied sexuality and SRH of 15–19-year-old people with disabilities, and found out that the youth are sexually active, but in risk of unsafe sexual practices. The other Kassa et.al (2016) research had a slightly different age group, and targeted 10–24-year-olds and showed that the group had a lack of knowledge in relation to SRH.

The total literature presented above is major. Still, the actual lives and situations of people, especially women, with disabilities have not been met with particular attention. The WHO (2011,pp.12–13) claims disability to be a development issue, and without addressing the actual needs of people with disabilities, it is difficult to advance their lives either. Hence, the topic of disability and SRH rights needs more addressing.

5. Theoretical and analytical concepts

The theoretical and analytical concepts of this research are related to access. The concept of access is a core component in building and creating healthcare services and their policies (Penchansky and Thomas 1981,p.139). For example Unicef (2019) mentions accessibility to include five components: physical, financial, bureaucratic/administrative, social, and information. Already in 1981, Penchansky and Thomas stated that access relates to one's ability or willingness to enter into, or the use of the healthcare system and services (p.128). They present five dimensions, or five kinds of relationships, of access to be able to describe it in a more detailed and precise manner: availability, accessibility, accommodation, affordability, and acceptability (pp.128–129).

In accordance with the previous chapter, there are multiple dimensions, and principles used to find out what challenges WWD have accessing SRH services in different global contexts. Sometimes these principles and concepts are overlapping and intertwined with each other. In this research, I chose to include concepts partially from the AAAQ-framework since its principles have originally been seen as the core components of the right to health, and to create obligations for states to make sure healthcare is timely accessible, acceptable, affordable, and of appropriate quality, without discrimination based on i.e., race, age, ethnicity, or any other individual feature (WHO 2017;WHO n.d.A.). Though these principles have been used in healthcare settings, they can also benefit other human rights related services, programmes, and facilities - such as schools, social work and social services (see also Unicef 2019). I have also adapted parts of Marin et.al's (2021,pp.5–19), slightly more specific, approachability, acceptability, availability, affordability, and appropriateness dimensions. Previously presented results from Nguyen's (2020) have also been noted, likewise the 6 A's from Katsui and Mesiäislehto (2022), and the above-mentioned dimensions of access by Penchansky and Thomas (1981).

The chosen concepts are assistance, affordability, appropriateness, availability, accountability, and approachability, because by merging and re-defining the previously mentioned concepts give a more coherent and precise picture of the relevant dimensions of access in this research. The concepts are used to reach the aims of this research - what challenges WWD have in their access to SRH services, what needs they have, and what are the reasons behind the challenges. The first concepts are used to analyze the challenges WWD have experienced, and the two final ones are used to understand the reasons and needs behind the challenges. Nevertheless, in this research, accessibility is considered as an umbrella concept - in which the other concepts of availability, affordability, appropriateness, and assistance fall under.

Accessibility

Accessibility is a concept, and a principle that the CRPD is based on (CRPD 2014). It is considered as the ultimate core for people with disabilities to have equal opportunities to participate in their societies (imid.). As mentioned, accessibility can be seen as an umbrella term - to access, other principles have to exist (Katsui and Mesiäislehto 2022,p.197).

Even if the concept of accessibility has different definitions, some common characteristics can be found. According to the WHO (2017), the concept of accessibility means that the health and healthcare services, facilities, goods, and programmes must be accessible to everyone. In this definition the concept consists of four overlapping dimensions: non-discrimination, physical, economical (affordability), and information accessibility (imid.). Furthermore, Vergunst et.al (2015,p.2) use accessibility in their study to refer to a person's ability to enter the healthcare system without financial, geographic, or organizational barriers. Similarly, Penchansky and Thomas (1981,p.128) define accessibility as a relationship between the location of the services, and the clients in need of them, without neglecting to take into account the transportation related aspects between these two locations; time, distance, and costs.

Correcting each singular access-problem does not guarantee accessibility though; rather it should be viewed as a wholesome concept where different dimensions and factors are present, and need to be taken into consideration simultaneously (WHO 2011,pp.70–71). Also, Katsui and Mesiäislehto (2022,p.197) state that accessibility is important to ensure to WWD, so that they have the same opportunities as women without disabilities, but also note its importance to

elderly or pregnant people, people using a minority language, or people identifying to multiple of these categories.

As can be seen from the broad definitions, accessibility includes multiple elements. Therefore, it is a very suitable umbrella concept to be used in this research, which has a focus on women's access to SRH services. WHO (2017) have suggested that to be able to measure this principle, we need to focus more on how and why these accessibility challenges exist, and to identify the most vulnerable and most affected people. Thus, this concept provides a great tool to study access, with the help of the other elements of it - the concepts presented further below.

Availability

Penchansky and Thomas (1981,p.129) define availability as a relationship between the existing, adequate services and resources, and the needs of the clients. In the context of this research, the relationship WWD have with the provided SRH services, defines the present level of availability. Similarly, the WHO (2017) and ECOSOC (2000) see availability to refer to an adequate number of offered services, goods, programmes, and facilities for everyone, but also as available resources, professionals and medication.

Matin et.al (2021,p.18) present availability to include slightly more detailed aspects such as accessible equipment, transportation, facilities, services, internet, assistive devices, and/or consultation. From this perspective availability also explores if the services are provided, and available for WWD in the right place and time, according to individual needs instead of general customs (imid.). It is important to see the person behind the disability, and their SRH needs and rights in a way that a person entering SRH services gets treated i.e., for their menstruation problems as acquired, and not for their prevailing leprosy. As an addition to the above, Katsui and Mesiäislehto (2022,p.196) link availability to equal opportunities for people with and without disabilities. They point out that this likely needs reasonable accommodation and affirmative action, which are often tasks of the service providers (imid.).

To sum up these definitions and aspects, in this research availability covers among others financial, geographical, informational, communicational, and attitudinal aspects. Thus the concept answers the question: does it 'exist' for WWD (Unicef 2019). The concept asks whether there are i.e., available SRH services, equipments, or assistance for WWD, or women in general,

do the surrounding society provide or ‘allow’ these for WWD, where are they located, are they cost-free or high-priced, do the WWD know of these services, or whether they are informed about the services in a way they understand.

These questions are obviously also linked to the concepts of appropriateness, and affordability. Even if the services do ‘exist’ for WWD, there might be additional challenges interfering with their access to these services (WHO 2011,p.70). Some women might have other, intersecting, needs that also require attention, and might crave stronger input from service providers and the professionals¹⁴ (p.72). WHO (2011,p.70) claims that ensuring the availability of services is the key in improving general accessibility of the services. In another context, availability could be considered as an umbrella term of its own consisting of affordability, appropriateness, and assistance.

Affordability

According to Matin et.al (2021,p.18) the affordability dimension is about financial factors - whether a WWD is employed or not, if they live in poverty or are financially dependent on someone else, if they are in a relationship or perhaps single, what are the public service and transportation options and costs, are they financially affordable etc. Penschansky and Thomas (1981,pp.128–129) continue with their relationship based-definitions, and describe affordability as a relationship between the prices of goods and services, and the clients’ ability to pay. They also note the service providers’ requirements of deposits or insurances (p.128). This addition is important to note - the, sometimes impossible to pay, total costs of SRH services, are not always about the actual service, but about the deposits or insurances that many WWD simply do not have. Also ECOSOC (2000) states that affordability is about financial accessibility, and requires all services, private and public, to be economically affordable for everyone. If services are not affordable to some people, the services can be considered as not available for them. This concept thus has aspects and elements of other concepts too, such as availability, and appropriateness.

Also in this research affordability consists of, similarly to Katsui and Mesiäislehto’s (2022,p.196) definition, not only the provided services, but also the other expenses related to the services, or SRH i.e., the assistive devices, assistants, interpreters, the medications, and

¹⁴ i.e., when a WWD has the information about gynecology services provided to her, but eventually cannot get on the examination beds because they are too high to reach from their wheelchair (WHO 2011,p.72).

transportation costs (see also Unicef 2019). Katsui and Mesiäislehto (2022,p.196) mention that often people with disabilities are from low-income, and therefore need more resources to access the same opportunities as people without disabilities. Affordability should thus be considered as regarding the whole family, or household, instead of only focusing on the sole individual. The costs WWD have to pay to access SRH services should be reasonable, and manageable given the women's and their household's finances (Unicef 2019).

Appropriateness

This concept has plenty of elements of another often (alternatively) used concept, acceptability. I have merged the two concepts into one because they both have elements of society and individuals. In this research, appropriateness refers to the surrounding society, religion, and the culture that the WWD are part of, to the values, assumptions and/or perceptions, and morals of that society - simply to the context the women live in. It is about how the women are seen, met, and valued by the society, and how the society members treat, and behave towards WWD (see also Matin et.al 2021,p.17). For example ECOSOC (2000) has similar elements included in their concept of acceptability.

Matin et.al (2021,pp.18–19) present appropriateness as a dimension that mostly regards the healthcare staff, who are not educated on how to effectively communicate with WWD. Appropriateness can also be connected to a respectful manner of providing SRH services in regards to i.e., the individual's own and collective culture, gender, confidentiality, and other available ethical principles (ECOSOC 2000). Similarly, the WHO (2017) requires that the healthcare services, goods, and programmes are culturally appropriate, gender-sensitive, meet the specific needs of diverse individuals and populations, and are carried out respectfully, following international standards of ethics, including consent, anonymity, and confidentiality.

The concept of appropriateness in this research also consists the womens' attitudes about healthcare professionals and the SRH services, not solely the other way around - most often shown in terms of characteristics such as ethnicity, age, location of facilities, religious connection, or sex or gender (Penchansky and Thomas 1981,pp.128–129). Another important relationship regarding this concept is the one between the way SRH services are organized to accept WWD, and the women's ability to adapt to these services, and the perception they have of the services' appropriateness (imid.)

Appropriateness also links to the other concepts - i.e., availability, affordability, and approachability. The way the society thinks about WWD affects how the women think of themselves, and the way the surroundings are built in the society¹⁵. These are situations where the society's assumptions and values are yet noticeable, and where appropriate accommodation and consideration should be in place.

Assistance

Katsui and Mesiäislehto (2022,p.197) state that assistance is an important factor in the lives of many people with disabilities. Without assistance, many opportunities would, unfortunately, still be out of reach for them. According to Katsui and Mesiäislehto (2022,p.197), assistance is thus a way to increase the realization of human rights of people with disabilities. Additionally to assistance, they also have affection as one of their '6 A's' (p.198). They mention affection as a part of the love, care and support received from one's family, friends, neighbors, or bypassers (imid.). Often these people are the ones helping out and supporting people with disabilities in their everyday lives - to lower, ease, or eradicate the challenges they face. Thus, I have included the principle of affection in this concept of assistance.

To summarize, in this research assistance consists of both personal assistance, and assistance provided in forms of equipment or other devices - whether these are provided, and if, who provides them, and at what cost. Assistance can also be seen as related to accommodation - to have systems or services conformed, or people to adapt to these with some help of modifications (Penchansky and Thomas 1981,p.128).

Accountability

According to the WHO (2017) this concept refers not only to the states, municipalities, and other duty-bearers, but also non-state actors, NGO's, and corporations to have and bear responsibility for the realization and protection of human rights. Human rights conventions (i.e., CRPD, CRC, CEDAW) have sections directed to the nation states, and other stakeholders, insisting them to take responsibility for respecting the human rights of all people. The ECOSOC (2000,Art.42) summarizes accountability in a similar way, adding individuals, families', and local communities' responsibilities in the realization of their rights.

¹⁵ If WWD are noticed and their needs are taken into consideration, the buildings would have suitable ramps, there would be more interpreters, and the SRH services would be provided without discrimination.

Katsui and Mesiäislehto (2022,p.197) claim that without accountability, the other concepts are left as voluntary and optional, instead of compulsory actions. To authentically implement the other concepts, there must be evaluation and monitoring of them, otherwise the concepts are at risk of being left behind, neglected, or ignored (imid.).

In this research, accountability is used to analyze the results, more specifically the reasons behind the challenges to see whether there are structural factors that hinder WWD to access SRH services, that are of the governments', or other duty-bearers' responsibility to provide.

Approachability

This concept includes factors that are linked to how the services are approached. The approachability towards the SRH services can vary due to poor knowledge or limited information about them, because of previous negative experiences the WWD have of the services, due to lack of transparency (Matin et.al 2021,p.5). This dimension thus refers to own experiences and preconceptions WWD have about themselves, their SRH rights, and the services they are entitled, or should have access to. As accountability, this concept is also used to analyze the results from a cause perspective.

The woman's impairment or disability might affect the experiences, preconceptions, and how approachable they consider the SRH rights and services to be (Matin et.al 2021,p.5). For example if one is not able to understand information due to certain kind of wordings or level of one's cognitive development, has difficulties in remembering instructions, appointments, conversations or other information, uses a non-predominant language, or if there is lack of other audio-visual information and material (imid.).

6. Methodology

This chapter presents the research process from the beginning to the analysis part. The chapter explains how and why this research was conducted the way it was, what kind of analytical tools were used, and motivates these choices. This is a non-experimental, exploratory research that aims to observe and record lived experiences of WWD in Addis Ababa (Bryman 2012,p.41).

The goal is therefore not to compare the experiences with some kind of absolute truth, but with the help of the previous literature, also place the gathered data in a global context.

Qualitative research was chosen because of its suitability in studying people, especially their individual experiences and stories from their own perspectives (Bryman 2012,p.399). Likewise, Rohleder et.al (2019,p.95) suggest that research on disability and sexual health would benefit of a participatory approach, i.e., inclusion of people with disabilities in the research process. According to them, this would decrease the assumptions people without disabilities have about the SRH needs and therefore services of people with disabilities, and have them instead identify and define their own needs (imid).

I chose FG discussions as a research method first and foremost because I wanted to get first-hand information from the women who the study directly concerns (Bryman 2012, p.399,471). The quote “nothing about us, without us” also framed the way I wanted to work. As previously mentioned, the quote is based on the notion that all research with a focus on disability should consult, and have people with disabilities participate, lead, contribute, advice, and in other ways be involved during the design and implementation. Accordingly, I tried to have WWD involved throughout the process to help and guide me to conduct this thesis so that it honors and represents their views in the best and most accurate way possible. Rohleder et.al (2019,pp.91,96) state that the underlying message in the above quote is to conduct research in a real partnership, instead of a division of people who research and people who are researched.

Additionally, I considered FG discussions to allow more room for agreements and disagreements, and might encourage everyone in the group to share their experiences. This kind of method could also give broader contexts of the topics, since ‘free speech’ in their own words would be encouraged. I believed FGs to be a better way to make the participants feel more comfortable talking about their experiences, rather than solely with myself. Most of the members of EWDNA have prior experience in taking part and sharing things in the coffee ceremonies where they discuss different topics related to disability. This assured me to continue with a group instead of only individual discussions. This decision was also the best option timewise - I only had three weeks to conduct my research in Ethiopia.

There were several ethically difficult situations, issues, and questions to consider in this research. These are presented in Ethics, Chapter 8.

6.1. Preparations

My research plan started in December 2021 with Abilis and continued further in the beginning of 2022 with EWDNA. Early on, EWDNA stated that they would prefer me to conduct the FGs in Ethiopia instead of online due to the lack and quality of internet access of the WWD. We agreed that the most important thing is that the voices of the WWD are heard and used in this research. I explained the need to confirm the travels from my supervisor and university, especially during Covid-19, and the on-going war and conflict in the northern Tigray-region in Ethiopia¹⁶. I was advised to follow the official statements of the Swedish traveling recommendations.

Abilis suggested paying for a local WWD to work as my assistant and English-Amharic translator during my research, in this way being able to employ a WWD, and help me out simultaneously. As Boersma et.al (2019,pp.169–170) also mentioned in their study, Ethiopia does not have official training for sign language interpreters, but the chosen interpreter for this research is also employed by EWDNA, and thus has gained plenty of experience and knowledge from WWD and SRH rights (Shumet, personal communication, July-2022). Although, the familiarity of the interpreter does not erase the possibility of issues of confidentiality (Rohleder et.al 2019,p.93).

I talked with EWDNA and Abilis about offering individual discussions additionally to the FGs due to the sensitive nature of the research topic, and in the case of someone wanting to contribute to the research in a more private setting. Some might have bad experiences: abuse, violation, or trauma regarding SRH. I asked what terms EWDNA preferred me to use in my research, ‘women with disabilities’, or ‘disabled women’¹⁷. We agreed to use the former; this choice is also based on the emphasis being firstly on the person instead of the disability (Withers 2012,pp.6–7; Rohleder et.al 2019,p.4). In accordance, I also use the term ‘women without disabilities’, although Withers (2012,p.7) criticizes this term of creating a binary division by presenting disability as something all of us are either inside or outside of.

¹⁶ I was advised to consider and prepare myself for situations where I could infect others with Covid-19, or get infected myself, and the possibilities of the conflicts spreading and increasing in Addis Ababa region, and eventually how these situations would affect my research and traveling. Russia’s invasion in Ukraine also created an additional dimension to the former considerations.

¹⁷ I asked this since Withers (2012,pp.6-7) states that sometimes ‘women with disabilities’ can be considered too medical, and ‘disabled women’ as a term people with disabilities have reclaimed - I had the impression that the latter was an outdated term.

An initial idea of conducting FGs in a comparison with two different regions in Ethiopia was eventually rejected. Though i.e., Bryman (2012,p.402) states that research conducted in more than one setting can increase the understanding and identification of the context of the research, and its effects on the researched people's behavior and thinking. Despite that the prior comparison could have enhanced this particular research, it was rejected based on the notions of time, the level of this research, and the rather strict travel restrictions by both the Swedish and Finnish Foreign Ministries.

I had the informational letter, the consent letter, and the FG discussions, themes and questions commented on by EWDNA and my supervisor (see Appendix 1, 2, and 3.). The themes are formed in a semi-structured way to give room to participants' responses (Bryman 2012,p.471). I used a lot of time finalizing the documents because they were to be translated from English to Amharic. This is also why the information letter is a rather long one. The consent letter includes an option to give one's consent on tape, in case written consent is not an option or a possibility. Abilis asked me if I could consider presenting them another separate summary of the results, in case there was other information found in the research that was not eligible for the thesis itself. Therefore, I added another voluntary option in the consent letter in case the participants wanted their experiences also separately shared to Abilis in this manner.

I created the FG topics to be as open ended as possible, so that the women could answer as much as they wanted to. An unstructured, flexible approach would give me a chance to focus on what the participants felt like sharing. I could also raise, or skip, topics, and/or ask additional questions based on the group's activity. (Bryman 2012,p.404.) The documents were sent to get translated to an Ethiopian translator professionalized in disability rights who has been working for both Abilis and EWDNA before. Based on the previously mentioned discussions with my assistant and the representatives of EWDNA about the local culture, religions, and traditions, I decided not to include topics about sexual orientation or gender identities. I decided that in the case of these topics raising from the participants themselves, I would have to decide what to do with that information there and then, and carefully consider the appropriate way to handle the data.

Together with my assistant, we decided to have the translations in between each turn of speech in order for me to keep up with what was being said. My assistant reminded me about a possible

compensation for the participants - to cover their transportation costs. She had a fair point stating that the women might all be giving up on something else to come and join the FGs. I decided to go with the same amount that EWDNA offers occasionally as compensation. We decided not to mention the compensation to the participants beforehand to avoid a situation where the women are taking part because of it. I also gave the participants tote bags and pens as gifts from Abilis.

6.2. Participants

Since I was in Addis Ababa only three days before the first FG, I had asked my assistant to bring up the topic in a coffee ceremony prior to my arrival, to inform the women about this research. Therefore, both my assistant and EWDNA were helping me in the prior sampling by informing women about my research.

Before starting with the FGs, I wanted to meet, and give the possible participants the opportunity to familiarize themselves with me in a coffee ceremony - see and hear how I look and sound. I also planned to explain the objectives of this study in advance in the hopes of raising their enthusiasm towards participating and creating a comfortable, low-threshold situation for the coming FG discussions. These familiarization plans unfortunately did not happen, since there was only one coffee ceremony during my time in Ethiopia. I did not know too much about the possible participants, except that they were members of EWDNA, and part of the target groups they worked with. Since this research is not focused on any singular specific impairment or disability, but rather on the individual's own definition of themselves, I did not include these details in the information letter (Appendix 1.).

The research was designed as a small-scale project, and I hoped to get at least two FGs so in total 6-8 participants (see suggestions in Bryman 2012,p.507). I thought this as an appropriate figure per group, especially with the interpreters present, the FGs would be bigger in size and most likely more time consuming than without interpreters. Nonetheless, I aimed to get as many participants as possible within the available time period - 20 participants in total was a goal discussed with EWDNA and Abilis.

On my second day in Addis Ababa, I met with my assistant at EWDNA's office. We received a list of members, who had participated in the latest coffee ceremony, to be used to contact possible participants. Thus, EWDNA worked as a gatekeeper in regards to the research by giving

me access to conduct the research, and to the participants to access the research (Bryman 2012, pp.85,151). With the help of EWDNA's social worker, we went through the list excluding members under 18 years of age, and the ones without a phone number. The social worker checked the remaining list and offered to call the members with hearing impairments, since she knew sign language. We aimed for 20 participants - four focus groups, with some available extra days in cases of illness, and no-shows. My assistant called to the remaining other participants on the list in my presence. Some women did not answer the phone, but the ones who did, signed up for the FGs. All in all we got 20 women to join the discussions.

6.3. Data collection

Data was collected at EWDNA's office by having FGs, an additional individual discussion with a WWD, and with the Project Coordinator, Fikirte Shumet, from EWDNA. Bryman (2012,pp. 501–503) defines FGs as an interview technique, resembling a group interview, that consists of several persons discussing certain topics at the same time, which allows a wider understanding of participants and their answers. FGs also enable people to listen and reflect on each other's comments, and raise up topics for discussion they think are important (imid.). The discussion with the representative was to get a professional view on the situation of WWD and SRH rights in Ethiopia, more specifically Addis Ababa. Due to the time constraints, no pilot testing was conducted.

There were five FGs groups in total. Four originally planned ones, and one extra due to some previous cancellations and additional participants. There was an interpretation between English-Amharic-sign language because I know neither Amharic nor the local sign language. The groups were a mixture of women with different impairments and disabilities. The total number of participants was 24. The group size varied from three to six. Along the week we got four additional participants to the ones we initially confirmed. Out of these 24, two were parents of another participant. Their comments are separately referred to in the results to give additional context. Out of the remaining 22, two had a visual impairment, four had a hearing impairment, six had a physical impairment, one had an intellectual impairment, and nine did not mention, want to share, or had an unknown or unspecified impairment. (See Fig.2.) Since there was only one additional individual discussion with a participant, I will not separate it from the other results for privacy reassurance. The age of the participants varied from early 20s to late 60s. Ten of the participants informed that they study, or have some kind of education, 13 that they have,

or have had some kind of work, eight said that they were married or were in a relationship, and 15 mentioned having children. One participant said they were originally from Addis Ababa, six from someplace else.

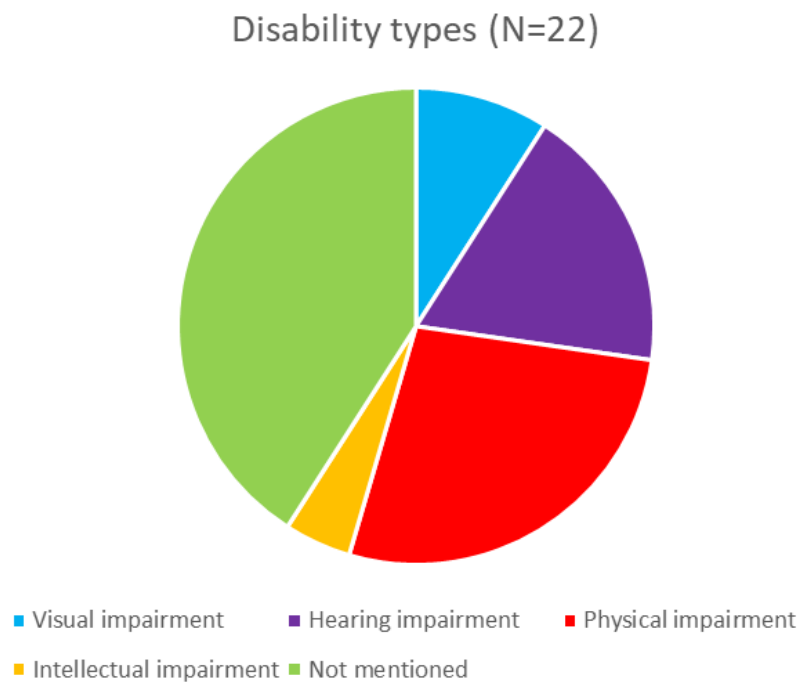


Fig.2 Disability types (N=22).

It was not clear from the beginning where we would organize the groups, since the office space was limited. Therefore we had to arrange the setting each time we met with a group. Unfortunately at times the location was not the most suitable option due to noise from outside the building, or from other rooms or spaces that staff members were using. Sometimes the groups were interrupted by staff who were not aware of the arrangements made in the morning. In these cases, we took a pause to avoid sensitive or private information being shared while others were present in the same space.

Each group started by reading the information letter out loud. This was done in order to repeat and remind the participants about what the groups are about, and to reassure that everyone of them had at least been given this piece of information. After this, I introduced myself and reminded them about the possibility of withdrawing their consent at any given time before October 2022. I also explained that at the end of the group I would like them to sign the consent form, to ease and calm the beginnings of the FGs. Thereafter, I gave the participants the opportunity to ask questions. Sometimes there were questions raised about my personal life,

education, or my interests in the topic, and sometimes the questions were more related to the topic; about the final product of the thesis, the reasons to sign the consent letter in the first place, or about my plans with the results after the thesis is published - some wanted to know what happens then, and if i will just forget about them after I'm done with school. I also expressed that due to Covid-19, there are facial masks and hand sanitizers available for the ones who need or want it.

I asked the participants to pay attention not to speak simultaneously due to the different languages used in the groups, and so that the recording machines could keep up with the comments. This would also make it easier for the interpreters to translate in shorter sections, which would potentially give more precise translations. I also pointed out that this way we respect everyone's comments, as well as their ways to express themselves and share their experiences.

6.4. Transcription

I started transcribing after the first FG, so that I would have a fresh memory of the discussions. To get started, I listened to the recordings and transcribed them in a simple, denaturalized, way by marking the participants name and the comment. I did not include sighs, short pauses or other nuances of the translated speech due to the language barriers. (Oliver et.al 2005,p.1277.) Some participants' comments in the transcriptions have been modified to a clearer and more understandable form, from i.e., 'she said', to 'I said', due to the way the translator and the interpreter presented the comments during the FGs. My initial plan was to have the transcriptions verified by the participants, but it ended up being a complicated process with the different languages involved. Instead, I had my local assistant go through the transcriptions with me, since she had also been present, to see whether we agreed on them. Eventually, I made changes to some words used according to our reviews.

The first FG recording was the most difficult one to transcribe due to multiple noises from the outside. Bryman (2012,pp.504–504) states that transcribing FG is often more complicated and challenging than individual interviews due to having to focus on all the different participants, and what they said. Also, the voice of my assistant was barely hearable. For the next FGs I had one of the recorders placed higher, and closer to her. The FGs that did not require a sign language interpreter were easier to conduct and transcribe. In the case of having a video camera

available, transcribing would perhaps have been easier. To get the person's name on record, I was reminding the translators to mention them before interpreting. Often, I had to ask for the names afterwards and it became slightly confusing both on the record, and for the live group, because of the interruptions (see also Bryman 2012, pp.504–505).

6.5. Thematic analysis

Thematic analysis was chosen first and foremost to be able to find results to the research questions posed in this research. By using thematic analysis, the gathered data was used to find themes within individual transcripts of a FG, but also across different transcriptions (Bryman 2012, p.13). The analysis thus enabled the combination of the semi-structured questions and answers, helped to identify themes, patterns and ideas emerging from the data, and to narrow broader themes into smaller categories - from where, in this case, the particular challenges could be found.

I started the analysis process by writing down recurrent themes after conducting the FGs. After this I added all the transcription files in NVIVO and started to go through them one by one. To create a thematic analysis I needed to create themes, consisting sub-themes and more specific codes, of the gathered data. I started with creating codes based on the FG discussion topics, and research questions. This kind of grouping felt difficult and became messy due to multiple overlappings, which is why I decided to code and group the data just as it was - by the occurring challenges. I read and re-read the transcriptions and in the end, re-grouped some of the themes. I finished with five themes that are presented in the Fig.3 below, and more further in the next chapter.

Society	<ul style="list-style-type: none"> - Prejudice - Attitude - Behaviour - Culture 	<ul style="list-style-type: none"> - Behaviour - Attitude - Violence - Neglect - Society - Family - Abuse - Prejudice
Information	<ul style="list-style-type: none"> - Lack of information - Communication methods - Confidentiality 	<ul style="list-style-type: none"> - Media - Medication - Lack of information - Lack of awareness - Confidentiality - Communication
Environment	<ul style="list-style-type: none"> - Physical accessibility - Location - Transportation 	<ul style="list-style-type: none"> - Buildings - Surrounding - Environment - Transportation - Services - Location - Living
Finances		<ul style="list-style-type: none"> - Transportation costs - Service costs - Unemployment - Social class
Support mechanisms	<ul style="list-style-type: none"> - Assistance - Assistive devices & equipment 	<ul style="list-style-type: none"> - Hearing aids - Wheelchairs - Personal assistance - Crutches - Others

Fig.3. The grouping of the themes

7. Challenges in the access of sexual and reproductive health services

This chapter presents the results of this research and views them in relation to the previously mentioned access- related concepts (Chapter 5). The results have been formed through both inductive and deductive principles, meaning that the gained knowledge has been formed both from the research data, and from the used theoretical concepts (Bryman 2012,p.28). The results are mostly linked to the healthcare sector and are placed within medical care. Shumet (personal communication, July-2022) explains that social work in Ethiopia at this point is mainly focusing on healthcare. The results complement this. Shumet adds that social work is a luxury service, since it is difficult to even provide the basic services (personal communication, July-2022). Throughout this chapter, the different theoretical concepts are present, often merged and linked to each other. As Penchansky and Thomas (1981,p.129) also claim, the different elements, or in

this case concepts, of access are tricky to separate and divide - sometimes they might overlap and prerequisite other concepts.

During the FGs, many factors were mentioned as challenging for the WWD in regards to their access to SRH services. The challenges are presented in the following categories: environment, society, finances, information, and support mechanisms. These have similarities to the categories Nguyen (2020,p.383) presented - social, physical and geographical, income, and educational barriers. Some of the participants stated that they face too many challenges to be listed down and explained, and few wanted to highlight that they have had good experiences as well. In general the women mentioned that the SRH services should be accessible based on their individual disabilities, and different disability types.

“So one thing we need, when we go to any hospital, we want them to make it accessible based on our disability. So, mainly we need accessibility, and flexibility as well, related to our disability.”

“Depending on our disability type...For example, if a blind person is coming, there should be someone who can assist, and also if there’s a physically challenged person, there should be accessible buildings.”

Though the various challenges were acknowledged by most of the participants, there were few who mentioned not having experienced any difficulties or challenges regarding their access to SRH services. A few thought this was due to their disability not “being as severe” or visible. Some mentioned that they had never sought to access any SRH services, and therefore had not experienced challenges. One mentioned that it is not necessary to compare women with and without disabilities in this matter;

“[...]because even if we have a disability, we have the same feelings just like any other person.”

7.1. Narratives of environment

This chapter presents the challenges the women had in regards to their environment. Their experiences were related to physical accessibility, the location of the services and of WWD, and to transportation.

Physical accessibility

One of the main challenges the participants faced accessing SRH services was related to physical accessibility. A participant explained how the inaccessibility is surrounding her everywhere - even in her own home.

“I think we are very strong, especially living in a developing country, like Ethiopia. Everything is not accessible, even our house is not accessible.”

Most often the participants referred to either inaccessible buildings or roads. The overall infrastructure was seen as bad and inaccessible. Without proper, accessible, and safe roads, the traveling to the services was challenging, and could eventually affect the willingness or eagerness to even try to access them. Thus, the concept of approachability plays a major role here. Some women mentioned how the inaccessible roads could even lead to a serious injury or death. Safety is an important part of physical accessibility (Unicef 2019).

“There's a hole on the road and people are walking through it and they got hurt and they even died. So, the road should be very accessible for blind people.”

“One time when I closed my shop and went home, I fell and I miscarried my child.”

The physical accessibility did not only relate to the infrastructure, also the buildings and provision of the services were seen as inaccessible. Beds and inadequate delivery rooms for example were mentioned as challenging to access. Many had difficulties in getting on the beds, because they are not height-adjustable. One woman highlighted the importance of providing WWD proper beds when staying in a hospital, instead of laying on the floor, to prevent them from becoming sick, and to ensure accessibility. This is bound to a sufficient amount of available, proper beds, and accessible rooms.

“[...]one time when I gave birth, the bed wasn't accessible for me, it was higher than my wheelchair so I couldn't reach it.”

“Because all the buildings are built for those without a disability, so we need special rooms.”

Few women mentioned that they have seen attempts of improvement by the government, which unfortunately are not always successful or accessible either. Some mentioned that the buildings might not have elevators or ramps, which makes it difficult to access the buildings, and the services.

“[...]the elevators are not working, some hospitals have elevators, but they don't work, get stuck or have other problems. They don't even care enough to fix it. So, they are inaccessible.”

“We still see buildings that are built now, but it's not accessible. Nowadays it has a ramp, but the ramps are not accessible at all. Nobody can walk on that, even without a disability. They just made it for a sample.”

On a few occasions the women said that people do not understand the purpose of the ramps. They mentioned that ramps have been used to move materials with, or they might have been entirely blocked with plants, gates, doors, or other inconveniences. These are examples of concrete, physical barriers causing challenges which could be fixed with adequate, available information about the purposes of ramps and other modifications to increase physical accessibility.

“Sometimes, even if the ramps are accessible, they put a gate on it, or they block it. They just build it, but they don't really know why...When we go to the hospitals, they're just blocked with materials, or something...they don't really know what the use of the ramp is in the first place, they do it just to not be caught by the government.”

“The ramps are not accessible. It's just for formality...They don't know it's for us, or it's for wheelchair accessibility. It might be very narrow and very slippery, so they don't know why they built it.”

As the previous quotes show, the ramps or buildings might be built but with unsuitable materials - which does not make the accessibility any better. Sometimes people might also think of carrying a person with a disability, which is not an appropriate solution to a human rights violation of accessibility. This would also be connected to the concept of appropriateness: what is appropriate and according to whom? The challenges with physical accessibility also made few women wonder why people with disabilities are not consulted about such things. One mentioned

that she would like to do training for companies to show them in practice the inaccessible elements in their facilities, and how they could fix those.

One woman mentioned that she thinks the society's continuous lack of awareness is causing the challenges in physical accessibility. Here we can state a connection between the information and environment -related challenges. This is also an issue of availability - equal opportunities are not available for WWD, compared to women without disabilities, in accessing these kinds of services or buildings (Katsui and Mesiäislehto 2022,p.196). As can also be depicted, some results were mentioned as both the causes and challenges. In the below quote we can spot how the manager is not available for the woman if his office is on the higher floors in a building without an elevator.

“[...]we have additional or special needs in order to access [SRH] services...For example, if I wanted to communicate with the manager, he might be on the fourth floor, so I need him to come down, then we can have a discussion...it's because it's [the building] not accessible for us...To move to the fourth floor.”

The importance of a physically accessible toilet was raised multiple times in relation to the access of SRH services. Toilets in a healthcare setting are not only vital for the healthcare services themselves, i.e., for urine samples, or other kinds of tests, but also for every person to use and have access to sanitation. To have physically accessible toilets would also decrease the women's need to ask for assistance or help, and increase their agency and independent participation. Although, even if the women asked for help or assistance, they can be dismissed due to cultural reasons, it might be considered as inappropriate. Some participants, with physical impairments, said that they have often abstained themselves from using toilets, because of their physical inaccessibility.

“Nowadays, the health centers are very modern, but the toilets...are not accessible, because most of women with disability use the one, [a toilet seat] like what we have here...the ones that are built there [health centers], don't have such thing, they are built on the floor, so they're not accessible for us.”

Sometimes the hospitals or health centers have accessible toilets, with toilet seats and sinks, but are still out-of-reach for the participants. One woman said that she had an experience at a

hospital she was visiting, where the toilet was on a different floor, which had caused her challenges. Another woman shared how in one hospital there was an accessible toilet, but it was not for use.

“They have a toilet that’s accessible for us, but they just locked it, so that no one can use it...[They say] It’s for staff in case we hire a person with a disability. It’s not for you, it’s for our staff...There are women who fell in the bathroom, in the toilet. Yeah, in the toilet. And they miscarried.”

Here appropriate accommodations are missing, same as an understanding of the underlying purpose of accessible toilets, or ramps. Physical accessibility as shown is connected to the overall SRH of the women, and is an important component in the safety of the women’s lives.

Location

The location of the services, as well as the person's home, or place of habitation, have a major role in the environment related challenges. Not all of the participants had a home, but were living on the street. Some women compared their experiences in Addis Ababa, and with their prior hometown someplace else, most often in rural areas of Ethiopia. Some shared that the infrastructure and the healthcare services are better in Addis Ababa.

“Due to living on the street, I am more vulnerable and exposed to abuse.”

“I came from [town], outside Addis. I came here to take further treatment and I found a person that has a similar disability than me, so that’s why I stayed here in Addis.”

The lack of education and services in their hometowns was seen as a challenge for the women to access services, and that being a reason to move to Addis Ababa instead. The location of SRH services is obviously very important, but also the source of knowledge and education - the schools. Some areas lack inclusive schools to people with disabilities, some lack schools in general. Few women had moved to Addis Ababa very young, some had to leave their own children and family behind in a later time of their lives.

“I was born outside Addis. And when they [parents] found out about my disability at the age of 5, they sent me to Addis, because there was no school or any facilitation there.”

“Even if my society back there are not that much discriminating, but my disability...restricted me from getting a formal education. I left my child when she was one year old. I came here, but if things were accessible or more inclusive I would learn and be in a better place right now.”

As mentioned, the location of the services is a key in accessing them. Few women pointed out that sometimes they have to rely on organizations' help when educating themselves about SRH rights and available services. Some women shared their experiences of giving birth at home, instead of seeking the help of healthcare professionals due to the far-off or unattainable locations of the services, as well as their own culture. Here we can see a connection between the societal challenges: how acceptable and appropriate the culture sees SRH rights and services can also affect the way WWD attempt to access those.

“I was living in a rural area. I wasn't even going to the hospital, I just gave birth at home and was in labor for four days...Thanks God, I finally gave birth to the girl...We don't know any doctors.”

The relationship between the location of the services and the women, while taking into account the time, costs, or distance were shown to be in a crucial role in the access to SRH services (Penchansky and Thomas 1981,p.128).

Transportation

Transportation was strongly related with the other surrounding environment challenges in accessing the SRH services. The majority of the women said they traveled from far away to attend to the FGs, which is why many of them also only seldom participate in the activities organized by EWDNA. The women explained that transportation can take up to several hours, they might have to change vehicles or transportation multiple times to access healthcare services. Shumet confirms this by stating that most of their members come from a distance and might have to use extremely crowded buses, which are a further challenge of transportation (personal communication, July-2022). This shows that there is a lack of available transportation. The costs of transportation were mentioned to have an additional challenge for WWD. Transportation was also strongly connected with societal challenges; society's assumptions and attitudes, as well as communication challenges between WWD and society.

“For example when I came here, on the transportation...they don’t give me the service because they think I cannot stand for that long. But I can do that, I teach standing for like 40 or 45 minutes in class. It’s easy for me to stand on the transportation as well, but they don’t think I can, so they don’t give me the service.”

Bad infrastructure leads to more difficult transportation, and possibly ultimately not accessing the service, especially in situations of emergency. A woman described how she went into labor while onboard a local taxi¹⁸, a car full of people.

“The driver didn’t know at first, I told him to be fast...and he just asked me what happened...I’m pregnant so we need to drive to the hospital...So, the driver tells the passengers to get out of the taxi...they said no we stay here with her, we will go with her, don’t pull over, just go...He took shortcuts and we arrived there.”

Transportation referred to more or less all the theoretical concepts mentioned in Chapter 5 - but mostly availability, affordability, and appropriateness.

7.2. Financial struggles

The concept of affordability is seen throughout the financial challenges mentioned by the WWD. Financial challenges go together with the environment, and information -related challenges. The fees of transportation, the SRH services, and their related indirect costs are at the core of the affordability concept, and were visible in the experiences shared in the FGs (Unicef 2019). Financial independence was valued among the women and strongly connected to one’s ability to take part in and receive healthcare services.

“I took a lot of training, but couldn’t implement the knowledge I got...due to financial struggles.”

Most of EWDNA’s members need some kind of economic empowerment (Shumet, personal communication, July-2022). In accordance, the women stated that often people with disabilities come from low-income families, and thus financial aspects play a crucial role in their SRH. Public, government owned healthcare services were said to have many challenges, few mentioned that the private clinics might be better.

¹⁸ The local taxi referred to here is a van that fits around 10–15 people. These are like mini-buses. They are privately run, and are a complimentary transportation method to the public buses, and taxis.

“[...]but if you have the capacity, I mean the financial capacity, you can go to private hospitals, they are much better.”

The financial challenges were connected to the incomes and expenditures of both the women as individuals, but also of their families, or other members of the household they were responsible for. Some women mentioned that when their living costs increase, they end up having multiple jobs. The results also pointed out other layers of financial challenges due to difficulty of securing employment, not to mention receiving one in the first place (see also Tefera and van Engen 2016, pp.4,16–17). Thus, finances are also connected to how women are seen by society (appropriateness), or whether they are employed or not.

Shumet mentioned that the government of Ethiopia remains to be more or less the only employer there is for WWD (personal communication, July-2022). According to her, it is hard to work for any other employer. Some women end up searching for a job abroad. One mentioned of having extremely hard time abroad, and faced extensive amount of sexual, physical, and medical violence, abuse, and hardship. The financial struggles can clearly have enormous consequences on one's SRH.

“I face these challenges because I am from low-income parents...[it] made me leave the country...I thought it would be a good opportunity to support my parents...The life that I had is the worst, even worse than here.”

Some women shared experiences where people had tried to take advantage of their financial circumstances on one hand by refusing to pay for their work, and on the other hand by asking for sex in exchange of money - something that was assumed the women were lacking.

“So, [society thinks] if I gave her some money, she would sleep with me because she needs money...so, they think we are always dependent, even if we get educated, they think we are always dependent, and don't have anywhere else to go.”

Also Shumet acknowledges the exploitation, she mentioned that children with disabilities are sometimes exploited in trafficking and used to gather money for the trafficker (personal communication, July-2022). As said, WWD were denied their salary, but were also paid less than their peers without disabilities, or had been fired due to their impairments. These

experiences were related to their employers, but also the other members of society. Shumet also noted that even if some WWD have savings on a bank account, they might not be able to withdraw their money by themselves, instead would need another person to do that with, as a witness (personal communication, July-2022), which can mean further need of assistance. It can also be discussed how appropriate this kind of requirement would be in regards to people without disabilities. The issue of not having access to their own money can affect the attempts of accessing SRH services.

As the above examples suggest, the financial challenges are multilayered and interconnected with other challenges. The most obvious concepts visible from this part of the data are the affordability - if WWD can afford the SRH services and the other related costs; availability - do the SHR services exist to a WWD without an income; and appropriateness - how the society views WWD and their economic lives.

7.3. Challenges in relation to information

The challenges presented here in this subchapter are overlapping and strongly connected with environment and society -related challenges. This category includes challenges of communication and its methods, lack of awareness, and confidentiality. These components are all linked to information in one way or another. Due to their strong connection, informational and societal challenges are influenced by and dependent on each other - most likely, if one would be overcome, the other would follow.

Lack of information and awareness

The challenge that was most referred to, was the lack of information and awareness. It was often seen as the main reason for all the other challenges they face.

“The...discrimination begins from when they educate about sexual reproduction. They give it to women, to the youth, such and such, but they never give it to women with disabilities.”

On multiple occasions, the women mentioned that the discrimination and inappropriate behaviour and treatment they had received, was due to the professional's lack of awareness and information about WWD and SRH rights. It was also connected to the women themselves. The women lacked knowledge about their SRH rights because the professionals lack information about WWD and SRH rights. One woman mentioned how she does not know what she would

even need to know, or benefit from, because the topic is so new to her, and was shifting the decision making to others instead.

“[...]they [healthcare professionals] don’t have any awareness of how they're gonna treat women with disabilities.”

“[...]we don’t know what's there for us, the rights and the obligations.”

These examples above paint a picture of unavailable services for WWD, and the lack of equal opportunities in accessing them. The citation below shows the professionals' way of behaving and not providing all of the information, perhaps due to communication challenges, and/or lack of awareness about disability and SRH rights, and to the woman’s lack of awareness concerning pregnancy. This example also has features of neglect and violence.

“I went to the hospital with my mom, and I told them I’m not seeing my period in four months...They just took a urine test, and looked at it at the laboratory...they didn’t tell me I was pregnant, they just gave me medicine and I started to see my period the next day...then after a long time it [periods] stops again, for four months. So, I just ignored it because I thought it was the same like previous one...because I drank too much alcohol...I just thought it [growing tummy] was that, but my sister noticed and asked me to visit a doctor, because I might be pregnant...I went to the doctor with my mom, and...they told me I’m 6 months pregnant...I was having my time, I was dancing, drinking, staying out for long, I wasn’t having any pain, until I reached 6 months...Because I took too much alcohol, I asked my doctor if my kid is alright and he told me yeah, you have a healthy kid. You don’t have to worry about the past, you should start thinking about the future.”

The story reveals how the woman was not given the information about a possible pregnancy the first time, but only given the medication to start her periods. She was denied the choice of deciding herself whether to keep the possible child or not. This presents an example of a medical and eugenic mindset from the professional’s side. Some women said they have had to find out information on their own since they have not received it from the healthcare professionals. Others mentioned that they themselves act as ‘teachers’ - when healthcare professionals meet them and get to know them, they start to understand each other in a better way.

“[...]before you get married, you have to gather a lot of information about it – about sexual health and about the challenges to get the services.”

“[...]if someone sees me for a second time, it won't be as challenging as it was on the first visit. So, he [doctor] might have some awareness about leprosy when he...see me again, or someone again.”

Many complained that they had received wrong, confusing, or inadequate medication or treatment due to the inaccurate or lacking information they had got. Multiple examples were shared in regards to i.e., contraceptives and giving birth.

“I have friends who don't know how to take the pills. Sometimes they are taking their pills while they are pregnant without knowing...I even know, when she gave birth, the kid came down with Down Syndrome because she took a lot of pills while she was pregnant.”

“I have a friend who didn't want to get pregnant, so she went to the doctor and she put a contraceptive on her hand. And it stayed for a long time, then she wanted to have a kid...she went to a doctor when she wanted to take that out...it couldn't be found anywhere in her body. So, they keep searching and this thing can still not be found. So, she cannot get pregnant because of that.”

One of the mothers explained how some WWD are given certain kinds of contraceptives against their will or without them knowing. Many of the women had not known anything about their menstruation prior to when they had it for the first time.

“[...]I didn't know anything about periods, so when I first saw my period, my older sister was laughing at me and I went into the house and told my mom, why is my sister laughing at me, what's going on.”

“When [daughter] asked me, is it only me or is it something that happens to everyone, I said yeah it's a normal thing, it's not something unique on you, you'll see this every month.”

Some women mentioned the lack of awareness about menstruation and sanitary pads to be a challenge. The provision of the pads is not equal or effective enough. Some said they had

received reusable pads from some organizations. Prior, some were using foldable cloths. The woman from the first quote above continued:

“[...]when she [mother] saw my clothes she told me, you are seeing your period. I didn’t know anything about it, and my mom taught me how to fold it and use the cloths...like a sanitary pad. But it hurt me, then I started using the one, which is, like prepared for pads.”

The information challenges were linked to where the women lived, or were physically located, and the level and standards of the services provided there. As mentioned in *Financial struggles*, some women implied that the services were better at private healthcare settings, which usually are located in the bigger cities.

“Where I’m living, there is an association...they taught us how to use the sanitary pads, and everything, they even gave the pads free. So, because this kind of education might not, we might not be getting it from anywhere, from our parents, so they taught us how to use the sanitary pads. There is also a pad...that you can wash and reuse again, so they also gave that.”

Majority of the women claimed that there is not enough information, education and training about WWD and SRH rights for healthcare professionals. According to their experiences, these topics should have more focus and emphasis on. The training and education was not only tied to the medical professionals, but the entire society.

“[...]even the becoming doctors or nurses, they don’t know anything about it, because they never get the education.”

“There should be more training regarding this area. For those who are working in health centers as well as for society, and even persons with disability.”

As these examples have shown, these experiences and challenges are very tightly linked to the broader societal and environment -related challenges, as well as the following communicational challenges. Issues in available information, both for the women and the professionals is a major weakness.

Communication

Communication was named as a crucial part in accessing information and services about SRH. The most often referred factor was that there is no sign language interpretation available. Hence, the vital information i.e., regarding one's health is not provided in means that are available and accessible for all WWD (see also Unicef 2019). This causes a major challenge for the women with hearing impairments, and leaves them excluded from the provided information and services.

“[...]I don't know anything, there might be [important information] but there's nothing that's interpreted.”

“Not hearing is a very challenging thing...when we go to the hospital, it's hard for us to communicate with them.”

One participant highlighted that these challenges are not only due to different ways to communicate, but in fact a complete language barrier.

“[...]the doctors have problems on how to treat a person with a disability, we cannot communicate, there's a language barrier.”

Communication challenges also created situations that could have resulted in bad outcomes, and placed the women in possible danger. The example below shows that the provision of information and instructions in a healthcare setting were left unattended, unavailable.

“So, I wanted my sister to be in the labor room with me, but they told me no one is allowed there, so I had a little challenge when the doctor told me to push or something, I don't know what he was telling me.”

As the previous subchapters have suggested, the challenges the women mentioned are overlapping and interconnected. Some communication challenges were mentioned to relate to transportation challenges as well. To access the SRH services, one has to physically get there first. A woman shared her experiences of having to create other ways to be understood.

“Because they don’t know that I’m deaf. I had a communication barrier...for example one time I wanted to go to this place, and when I told the driver’s supporter, he said what are you talking about, and I wrote it down for him and then I got in.”

Some women spoke about the media’s responsibility. They explained that for example, there is no news in Addis Ababa available in sign language. Some women felt like they were left out of the important SRH information, advertisements, and news, or given inaccurate SRH information due to the communication barriers between the spoken and other alternative communication. Illiteracy was also pointed out - some people with disabilities do not know how to read or write, sometimes due to the lack of education, sometimes due to their impairments. Thus, as pointed out earlier, there is not enough information available to WWD, in various alternative forms of communication (see also Unicef 2019).

“[...]for example, there is media talking about reproduction and health, on television, on the radio, something like that. But it doesn’t address Deaf communities – we cannot know what they are talking about, because there’s no sign language interpretation. And also there are written documents but there are persons with a disability who could not read or write.”

The unavailable and non-existing sign language interpretation had resulted in the participants being forced to ask others for help and assistance. This often meant to include a family member or a friend, who might know sign language and the local spoken language, to have access to SRH information, services, or treatment. Unfortunately, their companions are not always allowed to enter the premises, or the appointments. A few women with hearing impairments mentioned that sometimes even their hearing children help them with translations.

“I went there with my sister, because I cannot communicate with other people. When I tried to get inside...they said one person only, you cannot bring other people. She is my interpreter...So, I want her with me...they said no, you cannot go inside with her, you have to come alone.”

“[...]my child knows that I cannot hear...When [the child] hears someone calling me or some noise, [the child] tries to explain to me using sign language.”

This kind of solution requires that many of the women need to schedule their lives according to their family members or friends, who can help them. They might have to cancel or reschedule healthcare appointments if they cannot get anyone to translate for them, because otherwise they

could miss important information. These challenges were supported also by Shumet's similar comments. These kinds of situations relate to assistance - the need to ask for help, and appropriateness - what others think about helping and interpreting for WWD, are they willing, or genuinely interested to help, are they trustworthy, or do they treat the information they have learned in a confidential way.

Some hearing women also shared that since they know a bit of sign language, they have been helping women with hearing impairments at hospitals or health centers to communicate or understand others around them due to the absence of proper sign language interpretation or other alternative communication methods to the predominant spoken language.

“One time I went to health center, and I saw a woman who was pregnant, and hearing impaired, there was a lesson regarding sexual and reproductive health...Everybody was listening...there's no sign language interpreter, so she just said what are they talking about, because she couldn't understand it. Then I tried to translate it to her...because I know a little bit of sign language.”

Some women with hearing impairments mentioned that they have had encounters with members of the society who do not believe that they have an impairment. So, sometimes the family members or friends who know sign language have helped to explain to the other members of the society, or to the medical care professionals about the impairment in question. This kind of questioning one's impairments or disability shows major ignorance and rude attitude from the society's side. It craves a great deal of the WWD to defend and explain themselves to the society, to people they should trust for example their care and health with.

“[...]I always went to the hospital with my mom, and the doctors didn't allow my mom to be in the room. But she told them I cannot hear, and she's there to interpret what they are saying. At first, they didn't allow her, but after they knew she's the one who translated for me, they just let her be inside.”

“They always advertise, that's on the posters, ‘we give priority to people with disability’. When I see that advertisement and I try to get in [at the hospital], they always tell me I'm not a person with disability, so they want me to wait. Then...I cannot hear when they call me. So, that's why I always argue with them.”

There were multiple shared experiences where the women had communication challenges regarding their medication or treatment. Some gave contraceptives and child birth as examples of this. Some examples paint a picture of negligence from the medical professional's side. These experiences strongly link to the other informational challenges.

“[...]there's a pill that you can take for 28 days so you cannot get pregnant...there's nothing written on it in Braille.”

“I went to the hospital to use the birth control, and it was hard to communicate and try to explain myself and also to understand what they were talking about...it was hard for me to choose the birth controls, so I just got advice from my sister, so I took something based on her explanation.”

Despite the evident lack of a common way to communicate, and awareness of the professionals, one woman with a hearing impairment shared her experience of not wanting any medical students into her delivery room. She expressed how she would not know if they had any questions or would give her any treatments. She explained how it could be a situation of learning something new for the students, but she did not want to be a learning experience.

Confidentiality

As mentioned in the previous sub-chapter, the lack of sign language interpreters, has created challenges for the women with hearing impairments. Some explained having a family member or a friend as an interpreter. Some women might not want to share their feelings, personal health records, diagnoses, or treatments with others. Because of not being able to communicate with the healthcare professionals without an interpreter, the women are often forced to ignore the confidentiality concerns they have. These experiences are aligned with the comments from Shumet (personal communication, July-2022). She explained how their members with hearing impairments are very often taken away from the chance of privacy and confidentiality. These experiences are linked to approachability, assistance, and availability. The next example connects several of these concepts.

“[...]if we knew there would be a sign language interpreter, we could go there by ourselves and get the service. Just because there are no sign language interpreters we have to go with our family, we have to schedule our lives according to the availability of the family members, or in case they're not there for us, we just sit and miss something important there.”

Sometimes the provided information is not adequate, or enough, so that the women could make appropriate, wholesome and pervasive decisions based on it. One woman said that she has asked for additional information from a sister, because she thinks that she can trust her with her personal information. Even if the assisting person is a close one, there should be alternatives. Some topics in certain cultures can cause shame, or embarrassment to the woman, knowing that there are other people who know some of the most private information about herself - such as abortion, STDs, problems in menstruation or the genital organs, or questions that could be considered inappropriate (see also Unicef 2019).

“[...]I only took one of my sisters, because she can communicate with me well and...she is not telling about my personal life to others, she can keep secrets.”

On some occasions, the staff of the health centers provide general information for everyone, or share private information in front of others - ignoring and neglecting issues of confidentiality, or denying the opportunity to ask personal, confidential questions. Shumet (personal communication, July-2022) verifies this by sharing a story of a woman who found out about their sister's HIV from the sister's doctor. As a conclusion, the informational challenges are grounded in unavailable and inaccessible information, and inappropriate accommodation and support.

7.4. Societal challenges

People without disabilities can have assumptions and beliefs about people with disabilities, sexuality, and the intersection between them, and might therefore avoid having any kind of relationships with them (Rohleder et.al 2019,pp.23–24). This was apparent from the results of this research. Along with informational challenges, society-related challenges were the top two most often referred ones. Societal challenges have been divided into four categories: prejudice, attitude, behavior, and culture, based on the women's experiences. These challenges are particularly linked to access through the concepts of appropriateness - what is the relationship between the society and WWD, is there stigma regarding the use of the SRH services, and availability - are the services unavailable to women, WWD, or in general to all people with disabilities (see also Unicef 2019).

Prejudice

The society's predominant prejudice towards WWD was seen to rise from the surrounding culture, and to cause the society's attitude, and was thus also linked to the behavior of the members of the society towards WWD. The links between these four categories are strong, and further, there are more examples of attitude and behavior, which are rising from the prejudice. Most often the women mentioned that the society simply thinks they cannot do certain things;

“The big problem that I’m facing is that people think that...I can’t. They say you can’t do this...this is not for you, it’s not accessible for you, such and such things. It’s really bad for me...I work and I can do anything.”

“[...]most people think if you have any disability, you should stay at home or...we should get help constantly.”

The results suggest that WWD are undermined by society. The majority of the women said that the society's prejudice was often linked to sexuality, sexual health, relationships, or other SRH topics. The women considered that this undermining and the prejudice are challenging them in their pursuit of a family life. These are vivid examples of how appropriateness is connected to societal challenges.

“Our society, they don’t think we deserve to get married, to have a kid, to live a normal life just like other people.”

“[...]things are very challenging, because of the society norm, they think if you have any kind of disability you don’t have the right to get married or have a child.”

A mother mentioned that the society considers WWD to be without sexual feelings. She further shared how she was pressured by the society to give her child contraceptives to avoid a pregnancy. This confirms the previous notions of healthcare professionals' eugenic perspectives.

“[...]because people like her or in general, women with disability, are a problem to be born. So they shouldn’t have a baby, or bring other additional human beings to earth.”

This prejudice is of various degrees and includes (false) assumptions and ideas of WWD. Many women mentioned that they are considered as non-parent-material, not-worthy of a family or SRH services, or unwanted when it comes to a relationship.

“[...]just because I have a disability, the nurse didn’t think I could be able to raise my child by myself.”

“[...]they think we cannot have our own child, able-bodied children or any kind of feelings. Even when they saw my kids, they said oh my god these are your children, they are beautiful. And I told them I only have a disability, I’m just like anybody else, so why do you say that?”

“I once had a boyfriend, which was really nice to me, but his family didn’t allow him to be with me, so they just sent him to Canada.”

The latter quote presents an example of the strong beliefs society has of WWD - the woman in question mentioned the society wondering in almost disbelief that the beautiful children are hers - as if it would be impossible for WWD to have (beautiful) children. Many of the women stated that they need the society to understand that they have the same desires as women without disabilities, and that their disabilities do not per se affect their abilities to be pregnant and give birth.

“We are like just anybody else, so we have the same desire that any woman has. So, we like to have a family.”

“The feelings [the desire of being a parent, to have a family] that you have, are here, in you...I’m giving birth through my vagina, not by my legs.”

One woman stated that she thinks the society builds and establishes the SRH services on the needs of women without disabilities only because they do not think WWD have sexual desires and/or deserve these services. Shumet said, along with some women from the FGs, that the discrimination and prejudice starts from home, one’s own family (personal communication, July-2022). She thinks that if the family denies their members with disabilities of participating in the society or education, it increases the risk of them being harrassed. She also explained that if a WWD is not allowed to take part in society, neither are given the chance to know each other, to learn how to accommodate different needs or ways - which continues to uphold the prejudice

and falseful assumptions of WWD. This way the WWD are not represented or ‘visible’ in the society, and thus, are left out of all the important policies - this is another example of appropriateness and availability being linked to the challenges. The notions of Shumet are undoubtedly also connected with the other challenges mentioned in this chapter.

Shumet also expressed that disability is sometimes misunderstood or considered as a punishment from God due to a bad deed or other act (personal communication, July-2022). This was not mentioned by any of the WWD themselves, but was raised by both parents, who participated in the FGs.

“There is a lot of prejudice...They exclude us from society because they think it’s [disability] because God cursed us...because God doesn’t love them [people with disabilities].”

One of the parents shared that they have taken their child with disability to the ‘holy water’ in the church:

“[...]when she was two months old, she was very fat and she was not saying anything, she wasn’t like active...[after some time] I wondered why because the doctors told me that she’s a healthy child, so what happened to her. So, I took her to church...there’s holy water...and like in our religion, we consider that as a cure [for disability]. I kept on going there until she turned 15. But, I simultaneously took her to the hospital as well. And the doctors told me that she’s going to be ok if I just treat her patiently [let her be free, don’t shout at her, be patient]. Still now, I’m taking her to the holy water [not as often]. Now, she’s very, very fine. She can work.”

A mother also told about a time she was in the hospital with her daughter, and the doctor said to a pregnant lady sitting near-by that if she kept on looking at the daughter, she would also get a child with a disability. The prejudice society has towards disability was expressed to be strong, and deeply rooted.

Attitude

The society was described as very ignorant and impolite which was one of the main reasons the women faced challenges from the society’s side relating to their SRH rights and the access to SRH services. The society was also described in many other words - mostly in oppressive ways, or with a negative connotation.

“It doesn’t matter what kind of disability, if it’s severe or not, if you have any kind of disability, they are not welcome at all.”

“[...]the society talks, in a negative way, about disability but, you know, we can do anything that other people can do.”

The mothers expressed that the society does not seem to understand that anyone, at any time, can have a disability, and thus does not consider it relevant to adjust their attitudes or behaviors.

“There is a lot of discrimination or challenges because people think it’s their problem, it’s not mine. I will never be a disabled person.”

“Sometimes they think you brought the disability to yourselves.”

Majority of the women expressed that the ignorant and even abusive attitude of, particularly, medical professionals has created tons of challenges for them in their attempt to access SRH services, with equal treatment. Their access to the realization of their SRH rights is challenged due to these attitudes.

“There was news that a blind woman, who gave birth, just because she cannot see, they gave her a room inside a toilet.”

Almost all of the women had experienced discriminatory, and rude attitudes from the society, particularly questioning them being pregnant. Sometimes the women were asked how they did not know about their pregnancy, which is contradictory to the society’s willingness to provide SRH education to WWD.

“Being a person in a wheelchair...and being pregnant, society's assumption is not good. They just say wrong things about it, like why are you pregnant, why are you like this, when you are a person with a disability. They said it in a normal way, but it really affected my mind. They keep saying stuff that should not have been said. They said ‘Oh you're in a wheelchair, you shouldn't get pregnant, what kind of person is he’, you know the husband...They just passed me by, and their words are stuck with me.”

“When I was pregnant, I went to the hospital, I was in labor, when I called out the nurse. The nurse just told me to just shut up and to not shout, if I shout, it might die inside. It might get suffocated...the child inside me.”

Some women had received suggestions from the healthcare professionals to abort the child, or give it up for adoption.

“After I gave birth to my child, the nurse came to me, and told me there are families who need a child, so, she just gave me advice, if I need to give my child away...and when I asked her, why you tell me this thing, she just said I just wanna help you.”

“There was a blind woman, who gave birth to twins and the doctors said, because you are a blind person, you don’t need twins...She wanted to raise them, but they forced her to give them to other parents...And the society said good job, you did the good thing.”

The attitude is not entirely exclusive for the medical or healthcare professionals, also other members of the society have negative or unpleasant attitudes towards WWD. These can also have forms of abuse. Some women mentioned that they have even faced negative attitudes from their own family members, friends, or other loved ones. These situations lead the WWD, in many ways, to more vulnerable situations and at risk of facing extended challenges in realizing their SRH rights and to access SRH services.

“I didn’t know anything about periods, so when I first saw my period, my older sister was laughing at me.”

“Even if I’m born and raised in Addis Ababa, and I live with my parents, they don’t want me to study. Because once I learn, they know I’ll be able to live independently, I will move out, so they don’t want that. They just want us to stay at home and to support them at work, at home...They don’t want us to study, because they think we’ll leave them alone.”

Shumet stated that the families are often also met with discrimination and negative attitudes, placed under shame and told that children with disabilities are not worth investing in (personal communication, July-2022).

Society's prejudice was strongly thought to relate to the lack of information and awareness. This was seen to create challenges in their lives in general, but also closely connected to SRH rights.

“Even if there’s a right, they are not respecting it, they don’t give it to us.”

One woman pointed out that maybe they experience these challenges because the medical professionals do not care enough, maybe they are bored or have too many patients. The negligence and ignorance had also caused one woman a close-to-death experience. Many of these challenges are overlapping with the broader informational, and environmental challenges, as well as the behavior of society, and linked to the theoretical concepts of appropriateness, and availability.

Behaviour

The society’s attitude is most apparent in their ways to behave, act, or treat WWD, especially in regards to their SRH rights. This is where the concept of appropriateness is very present. Regarding the behaviour of the society, the women also linked it to violence, neglect, discrimination, and abuse. One woman explained that the society thinks WWD do not have STDs and are therefore risk-free to have sex with.

“[...]we are facing too many challenges...we get raped, we get abused.”

“So, guys came to me and said, I’m doing this for you, you should see what other women are seeing, you should experience these things [sex]...they’re saying they’re really helping us...they just tell us to do these things. They try to fool us. You have to see it, I’m doing this for you, you have to see what other women are seeing or what it feels like. Yeah, like they’re doing us a favor.”

A few women even pointed out that WWD themselves should be more active and involved in the community to get closer with the members of the society, so that the society would not discriminate against them. The experienced neglectful behavior or treatment was most often located in a healthcare setting. According to the participants, WWD do not get the same treatment in healthcare settings as other women do.

“And because they have this kind of attitude, they just don’t give the right treatment that we deserve, they just tell us why you get married or why you have a child, just because we have a disability. But we have the same desire as other women.”

A woman shared her story and experiences of the neglectful, dismissive behavior of the healthcare professionals, when she fell and miscarried her child while coming home from work.

“It was 8 months and the child inside me died. When I went to the hospital to get a treatment, to get that from me, the doctor and the medical center told me, why you even get pregnant, why you do that...while being a person with a disability...They didn't want to give me service, so I had to carry my dead child inside me for 8 days...they weren’t even polite, they didn't give me the service because I have a disability...I had to press charges to get the service.”

The poor treatment was often linked to the level of knowledge a person has about disability, showing yet again the link between the societal and informational challenges. These situations and experiences were mentioned as raising strong emotions, confusion, and in some cases even fear.

“[...]even the doctors have problems on how to treat a person with a disability.”

“And, then I went to the hospital and when I told them I am blind, they told me no no no you can see, wait in line.”

The latter quote shows how appropriate accommodations could have been placed to ensure the access to the service the woman was going for. Some women had experienced that the medical professionals make decisions for them, such as deciding the method to give birth.

“Women without disability, got the chance to choose. But for women with disability, they just decide to have a c-section.”

“When I was pregnant, they [midwives] said, just because I have a disability, I should have a c-section...But my doctor tried to convince them, I can do the labor...and I gave birth through labor.”

Some experiences had violent, abusive aspects that can also have led to additional trauma, bruising, bleeding, or other kinds of outcomes. A woman shared about the delivery of her first child. She explained how she traveled to a hospital, but the nurses wanted to send her away.

“Like the baby almost came out, but they...referred me to another hospital...I was trying to explain that I can't go to another hospital, but she [nurse] just pulled my arms, and just pulled me to the car. When I tried to get into the car, I couldn't do it, the nurse came in and grabbed my legs and she saw the baby's head. Then she called other colleagues and they grabbed me back to the bed...and the baby got out fine.”

The above experience was truly challenging for the woman in question. She was first denied the service, and was not believed when she explained herself to the healthcare professional. She was not met or treated in an appropriate manner. Another woman shared a traumatic, painful experience, when she was forced to go through an illegal abortion. She expressed that the metal materials used in the procedure really resulted in a massive bleeding, and damaged her vagina.

“I didn't even know if I could have a baby afterwards...It was a lot of pain.”

In a later stage she shared that she did eventually get pregnant, but that the delivery had caused her a lot of pain.

“[...]they asked me if I ever done any abortion, and I said no. I lied...they told me, my vagina is not ok...It looks like you have done abortion.”

A woman shared an experience that pictures the abusive and violent behavior from different members and aspects of the society. She had met a woman in a wheelchair crying in front of a hospital. This woman had been raped by her foster father - he had brought and left her to the hospital to get checked if she was pregnant, and if so, to get an abortion. The woman had been insulted and neglected by the healthcare professionals, and eventually denied treatment - in other words not being treated appropriately with respect. This example presents how WWD face discrimination from individual and structural directions. A mother shared how a girl with Down Syndrome had been raped by her own father. She said that the society knew about it, but did not interfere.

“[...]the society kept saying to me why you care, she’s worthless and she should do that for her father, you know because she is worthless, so she should be worthy in this way. So she should be ignored...why you care about her life.”

Experiences with police were mentioned by the mothers. One of the mothers also shared how once, a person close to their family tried to rape her daughter.

“[...]I reported it and the policeman told me, what are you talking about, who cares if she got raped or not, she doesn’t even know it.”

Same behavior was repeated in another case, when she took her daughter to a hospital.

“[...] the doctor’s told me, what are you talking about, why you bring her here, she doesn’t even have any feelings and why even care if the person is trying [to rape her] or not. So, I said, even a person with a disability has a right not to be touched without their permission.”

Another example shows how the women might not always realize the abuse or violence that they have experienced and interpret those situations as something else. Such as in the example below, these can lead to unwanted and non-self-inflicted challenges. One of the women had two friends, she had a crush on one of them [A], but the other one [B] was in love with her, and did not want to lose her.

“So one time I went to the club with [B]. We were dancing and drinking too much...and we slept together. In the morning I saw a condom on the floor, but I didn’t really know what’s going on, so I asked him, and he told me we slept together, but we were using a condom...I was planning to marry [A], but...I found out that he has a child...he hit me [and asked] where did you find this kind of rumors...I was so panicked and I left him...after four months I went to the doctor and found out I was pregnant...to [B]. By the time I was 6 months pregnant, we got married...He [B] did that on purpose because he thought I would end up with [A]. [B] was really in love with me. So, if he makes me pregnant, I don’t have any other choice, I will end up with him...He lied, he told me we were using a condom. If he told me the truth, he knew that I would have used the 72-hour post pill...he didn’t force me [to marry]...but he like took advantage of me...he was truly in love with me...So, after I gave birth he told me the background story...if he didn’t do that, make me pregnant, I would never get married to him.”

From the example, we can say that B's (and A's) attitude, and the choices he made affected the woman in multiple ways. The woman was put at risk of facing diverse challenges in regards to possible STDs, unwanted pregnancy, additional SRH services and the costs related to them, as well as 'forced' marriage. Shumet (personal communication, July-2022) shared how it is very common for WWD to face sexual harassment, or violence. She said that many WWD do not know what to do with the problem, they might not have the confidence to report it, or they don't know all the forms sexual abuse can have. She also stated that sometimes WWD might not report the sexual abuse because they are dependent on their abusers.

As also Shumet presented, even family members and other close ones have been treating the participants in demeaning ways. Shumet, along with few participants, expressed that some WWD can be "locked inside" their houses and craved to do domestic work, without any access to education, healthcare, or society (personal communication, July-2022). A parent participating the FGs said that she hinders her child of participating in social events, and possibilities in meeting or creating relationships, because she is afraid of the child facing discrimination, abuse or violence, such as rape. Many of the women explained how they are used, and taken advantage of, and exploited, due to their impairments or disabilities.

"[...]there was a woman...after their divorce...her husband took one child to Kenya. And the other one she returned to her parents. And her father raped her daughter."

"[...]my aunt was the one who took me, promising my family that she would send me to school, but she wasn't supportive that much...because of the lack of awareness, she just made me wait at home, because she didn't think sending me to school is really relevant, as long as I have something to eat."

Even though this research focused on the challenges experienced in the context of Addis Ababa, some women shared that they experienced major discrimination from the society also back in their hometowns. This discrimination is sometimes extended to cover their family members as well.

"It's very challenging back there, they don't even get married, our sisters and brothers, our relatives, because I have leprosy."

“Back to my place, they are not very welcome, they just discriminate, they even discriminate my family.”

Both parents present at the FGs also made it clear that they do experience major challenges, and discrimination from the society due to having a child with disability.

Culture

The surrounding culture is obviously connecting all the other above-mentioned societal challenges. The challenges vary and depend on the predominant culture, including religion. Some women mentioned cultural, traditional, or religious practices influencing their SRH rights and the services.

“[...the placenta] doesn’t come out so...the remaining stayed in my stomach for three days. I had to take cultural medication to get rid of that. Like traditional medication...So the women tried to massage and pull it out from my stomach. So, everybody thought I would die. I was dying.”

“We don’t go to hospitals, we just give birth there, at home.”

“When they [an organization] give us the lesson to cook, when you’re cooking you should be clean and neat, so, because we are seeing our period, they don’t want us to be ashamed or feel like we are not clean, because of that, they just provide sanitary pads to use as well, they consider it a part of sanitation process.”

A few women discussed how their own families have treated them. One expressed how her own mother thought it was a good thing for her to be pregnant, though it was a surprise and what the predominant culture considers ‘out of wedlock’. The below comment also shows the idea of a mother as to stay at home instead of having fun with friends.

“My mother was very excited when she found out that I’m pregnant...Because I used to go out with my friends, spend the nights out. So, they’re [family] really happy because I am now a mom and I have to stay at home.”

Another woman shared her experiences of telling her mother about being pregnant.

“When I found out that I am pregnant, I wasn’t sure how to tell my mother, so I didn’t return home. I stayed at my friends for 5 days...So my mom was wondering where I went and when she asked my friends, they told her I’m ashamed because I’m pregnant. And my mom said it’s ok, I’m with my boyfriend, so it’s a good thing. I mean, we have this kind of culture...when you are trying to get married, your fiancé sends the elders to her parents and then requests her parents to give their daughter to him. Then my mom said I should do that.”

The example above indicates that if a woman is pregnant, it is expected for her to get married as well. Some participants expressed that men who do not follow the rules of a religion but instead prioritize their own feelings and desires, create challenges for WWD in regards to their SRH rights, and eventually their access to SRH services.

“As I told you, we have different kinds of religions. And, rape, abuse and such and such things are like really forbidden...all religions consider those rules are from God. So, they [the men] just don’t want to follow the rules, what the religion preaches, they just do whatever they want without respecting what they’ve been taught, without respecting God’s will.”

“[...]someone is getting raped or something, it’s because the guys just prioritise their feelings rather than saying this is not right or something. They just always prioritize their feelings rather than considering others, or the consequences that follow [to the victim and the perpetrator].”

As a summary, the societal challenges are mostly connected to the concepts of appropriateness and availability. How the relationship between the WWD and society looks like, and whether the SRH services are provided and available for them.

7.5. The lack of support mechanisms

Assistance was present in the challenges regarding support. The women mentioned not receiving enough support, either personal or through a variety of devices and equipment. It is vital to provide individual, personalized support to WWD, based on their needs, because it is the key for them to equally participate in society. The level of support should not be excessive though, otherwise it can expose the women to become even more dependent on others, and decrease their own agency and autonomy (see also Tefera and van Engen 2016,pp.5,20). The goal is also not to have things done for them, but to help and support them to the point that they can do it themselves.

One of the mothers said that she is the only one taking care of her daughter because she does not trust anyone else to look after her.

“I don’t have any other work, I’m always there for her. Because if I left her behind, she might face like sexual harassment maybe...maybe the neighbours, or someone who is in the house might attack her or sexually abuse her. So, I’m always by her side and take care of her. She’s [+20yrs], but still, I’m not allowing her to sleep by herself or with other kids. She is sleeping with me, I’m the one cleaning her, or washing her body, even when there’s rain outside, I’m not allowing her to go out by herself.”

Shumet (personal communication, July-2022) said that sometimes parents have difficulties with the boundaries: what is protection and what is a violation of their children’s rights. The mother from the previous quote also mentioned that their societies sometimes ask her how long she will keep doing this to her daughter.

“[...they ask]Why don’t you let her out and play with other kids, or let her go. I always tell them, if something happens to her, I won’t forgive myself. I don’t want anything to happen to her, she’s my daughter, my responsibility, so I’d be there for her every time. Because she is not that aware about herself there might be a bad person who can do something to her...when I’m seeing girls getting raped or sexually harassed on television, I really feel sad, I don’t want such things to happen to my daughter.”

As said previously, some women also mentioned that they are considered as not capable of doing a lot of things. Both ends of assistance, dependency, and support were thus present in the FG discussions. These are connected to environmental, societal, and informational challenges. The theoretical concept of assistance is evident in the challenges related to support.

The lack of medical professionals' knowledge often led to situations where the women were left alone without any support, help, assistive aids, or other personal assistance in circumstances where they would have needed it.

“I’ve had two miscarriages, and when I got there [hospital] to get a treatment, they don’t know how to treat me, they even told me to walk long distance to the surgery room...while they give me the anaesthesia...But there’s a wheelchair there in front of me, but they didn’t allow me to sit on the wheelchair...they said you shouldn’t use the wheelchair, it’s not allowed in there. So, I

was shaking, I was very dizzy and at the time if I fell and hurt myself, who's responsible for that?"

The lack of emotional and physical support was evident in the above quote - the woman was not offered or allowed to use a wheelchair, nor was she given any consideration regarding the loss of her child. Here the concepts of assistance and appropriateness are visible. Also, regarding the denied access of the wheelchair, even though it was physically there, it was still not available for the women. The lack of support was not only related to healthcare professionals. Some women rely on the help of other people, such as family members, also because of their own cognitive impairments, or lack of knowledge or understanding about SRH, such as in the quote below.

"Whenever I'm seeing my period, I ask my mother how to use the pads, and when it's done, I take a shower."

Some women use assistive aids and equipment, but have also faced, even further health related, challenges because of them. They reported of discrimination and negative assumptions related to the use of the devices. Some had stopped using their assistive devices, such as phones or hearing aids in public, due to the discrimination they had faced.

"She thought my hearing aid was my earphone. And I was using my phone, so she thought I was listening to music, so why are you listening to music if you are a deaf...because I thought people might insult me or get me in a wrong way, so, I stopped using my hearing aid after that."

"[...]the hearing aid...it stopped working, because I wore it every day and every night. And, it even gave me an ear infection."

These assistive aids are in a vital role concerning the women's access to SRH services - they can be i.e., their way to communicate, understand, or move. Support was thus also related to the other challenges - to the lack of interpreters, ramps or elevators, toilets and sanitation, emotional support and appropriateness, wheelchairs or crutches, as well as people's assumptions or willingness to help if asked.

8. Reasons behind challenges

This research focused on finding out challenges WWD have had in regards to their access to SRH services in Addis Ababa. It also aimed to discover what kind of needs, and reasons there are behind these challenges. This aim turned out to be more difficult to reach, due to the lack of answers regarding it. This question, that was also present as a FG theme, can have been misunderstood due to certain wordings, or the language used by the researcher. Two main topics for the reasons behind the challenges occurred from the data: the government's role, and the internalized picture WWD had of themselves.

Government

The majority of the women mentioned that the challenges they have faced have a connection to the state's failed, exclusive, or non-existent actions or policies. They claimed that the government lacks responsibility and that the current legislation regarding WWD and their SRH rights and services are poor. Here in this matter, the concept of accountability is present. The women stated that these policies were a cause of the challenges, and thus should be changed in order for them to get equal access to SRH services.

”So the government really needs to work because the government accepts those conventions [i.e., CRPD]. And also there are a lot of policies for the society, so as much as they give concern for those without disability, the government should really make change for us as well, to have a better life for persons with disability.”

The women mentioned that their rights are not realized in a similar way as other women's, and this creates SRH challenges for them since they are not seen equal in the eyes of law. The same, equal treatment is not available to them. The main reason for many of the challenges were said to be due to an inadequate and problematic execution of the laws. These are structural level challenges: WWD do not have access to the government provided services. One woman mentioned that even some OPDs and their representatives are not to be trusted to actually do their work and help remove the challenges.

“We have the law, but the people who are assigned to make it active or to use it, they're just not doing their job...there's nothing in action.”

“[...]there’s a right for us, even if it’s not specifically said these rights are for women with disability, it says women in general have the right.”

The women felt that the poor execution and realization of their SRH rights is linked to the way the society treats them. Here is yet another example of how the challenges, the causes as well as the theoretical appropriateness, accountability, availability, and approachability concepts, are all interlinked and overlapping.

“We do have the rights, but the society doesn't know or doesn't believe that we have that right, so we cannot access or practice those rights.”

The execution of the laws was thus connected to the government and their inability to monitor and follow-up with the legislations. Some even suggested that OPDs should help in enforcing people to follow the laws while others thought the government should make changes and erase the challenges.

“[...]yes, we have the laws, but there’s no action. For example, the government doesn’t allow a building without a ramp, so the building owners just build their building, and they have a ramp, but it’s not accessible...it’s, just to not be punished by the government.”

Some discussed the fact that they are all taxpayers, and the government should therefore pay more attention to how the WWD are treated and how their lives could be improved and become less challenging.

“We are taxpayers...We’re paying those taxes, but the government doesn’t make it accessible for us – the buildings, the roads, and everything, in general the infrastructure.”

Other structural, governmental issues were mentioned by a mother present in one of the FGs, she explained how sometimes the police or other government bodies mistreat WWD in cases of reporting sexual violence or abuse.

“One time I took [daughter] to police because there was a guy, who tried to rape her, and the policemen were laughing at me: why you even bring her here... she got to court, she explained everything, then the judge really cried and the person got locked up. But after three months he was released and he was a free man, so there’s no law for us. She [daughter] can explain what

happened to her, that's why he went to prison, but there are...girls who cannot express what's happening, so there are a lot who got raped by their father, their brother, and they just sit in their home without any fair judgement.”

Shumet also provided an example of the police requiring eye witnesses from a blind woman coming to report a rape (personal communication, July-2022). Some women mentioned that they have been forced to take legal action to get fair treatment. Some had pressed charges or sued for example the healthcare professionals, or the entire hospitals.

“I even had to press a charge to get a treatment, to get that thing [dead child] outside from my body.”

As mentioned in the environment -related challenges, some women had experienced that there was no treatment available for their impairment in rural parts of Ethiopia, and therefore were forced to travel and move to the capital city. This was mentioned to cause a double-problem: more people will come and move to the capital city and put a strain on the city's existing infrastructure and services, and simultaneously shifting the focus from creating more awareness or healthcare settings in the rural parts.

“Back where I was living...it wasn't that much comfortable or inclusive, so in Addis, there're many persons with disability, so it's more convenient to live here.”

Internalization

This subchapter focuses on the women's internal experiences and thoughts that they considered to be causing some of their challenges in the access of SRH services. As reasons, they mentioned the disability or impairment itself, their own level of awareness and mindset, and personal characteristics. These causes can be connected to the approachability concept - how fitting, allowing, or worthy do the women see themselves in relation to the provided, affordable, and available SRH services.

As said, some women mentioned that having a disability can in fact cause a challenge of its own. Examples of this were mentioned: for a woman with an intellectual disability the disability itself can challenge their understanding and learning, or if one's sexual and reproduction organs are affected by their disability or impairment. Some comments were more linked to the timing of the

identification of the disability or impairment, if it was identified, diagnosed, or “found” early, it would more likely not cause as many challenges. The women suggested that there is a difference in what kind of, how severe, or visible the disability or impairment is to the society, and what kind of challenges they face. Many of the participants said that their own level of knowledge and understanding about SRH and their disability or impairment also affects, or more so creates challenges for them in forms of negative feelings about themselves, or by placing them at risk of health related problems.

“So, by not knowing about it [SRH] I might face infertility or have STDs. So, knowing about this really saves me from any kind of problems that I would face because of not knowing it.”

“I was in a panic when I first saw my period.”

“When [her daughter] first found out about her period, she said please hide me because my brothers and my dad don’t know about it.”

As the latter quote shows, through internalization, the women are at risk of believing the society, instead of themselves in regards to their capabilities, worthiness, or rights. The woman asking her mother to hide her suggests that she was embarrassed, or ashamed of having periods. This might not have anything to do with her impairment or disability; it can be about what is considered appropriate or shameful in her society in general. According to Shumet (personal communication, July-2022), WWD do not all know, or understand their basic human rights - that exploitation, harassment, or abuse are all rights violations. She adds on that very often WWD do not know they are highly vulnerable to and targeted by this kind of behavior. In order to implement and fight for their rights, or to demand equal treatment or service they must first have these rights internalized within themselves.

“We have to believe that we deserve, we have the right to get the proper health treatment, and also we deserve to get married, to have a kid...we have to believe that we deserve the right to exercise our rights.”

“In order to know the right [SRH], first we should understand we deserve this life.”

Some women mentioned that knowing and being more aware of SRH rights, and of the challenges related to accessing the SRH services, helps them to avoid and to deal with the challenges, and to improve their situations.

“In order to avoid having an abortion we should know what really sexual reproduction means and how we can protect ourselves. What are we gonna do and what kind of contraception we should take...in order to avoid coming challenges or any illegal abortions.”

Part of the information and awareness they had received was from a variety of organizations and their representatives. Some thought these people to be the reasons they have not internalized ableism, that surrounds them within their societies, but consider themselves as worthy, independent, and strong. Some said that they are also trying to educate others about SRH, with the knowledge that they themselves have. If they knew more, they could help others more as well.

“And, when my sister’s daughter...started to see menstruation, I told my sister, I’m not gonna laugh at your daughter, like you did, I’m gonna teach her how to use the sanitary pads, and what it’s about.”

“While I was working as a mentor, I gave advice and shared my experiences and tried to support those who are facing these challenges. I try to make them aware.”

One of the women stated that a member of an organisation, such as EWDNA, would probably not be a victim of rape, or other kind of sexual violence because they are more aware of the dangers from outside, than some other women are. She continued saying that they might not be as aware of the dangers rising from within their own families for example. It shows how WWD might be aware of the dangers strangers or “outsiders” could cause, but not of those who they are more familiar with. This was backed up with Shumet’s experiences, according to her, WWD sometimes do not understand, or recognise the exploitation, harassment, or assault conducted by their family members, who instead are assumed to protect them (personal communication, July-2022).

One woman also mentioned that she probably is privileged compared to some other women, because she has had so many possibilities and opportunities in life, without major challenges or complications.

“I probably get the opportunity to get good things compared to others. But there are others who have the same disability, who might face a lot of challenges. Like maybe their parents did not allow them to go out of their house, to get education, also some of them are not seeing the sun.”

Some of the participants, particularly in few FGs, highlighted that the challenges they face are related to what kind of mindset they have of themselves, and how they see themselves - their internalized feelings and thoughts.

“[...]I’m not ashamed of myself.”

“I think we are very strong, especially living in a developing country, like Ethiopia.”

The women explained how it is important to keep a positive and strong mindset, because otherwise the surrounding society can, and most likely will, take advantage of them. They pointed out that if they have faith and believe in themselves, they will have less challenges and better access to SRH services.

“[...]most women with disability they’re just scared to get married, or to be involved in this kind of relationship. They don’t know if there’s a challenge or not, because at first, they just back off...Because I’m married, I’ve seen the challenges, but most of the women with disabilities exclude themselves because they are scared of the discrimination or the society norms. So, in order to know the right and our obligations as well, we have to experience this life [relationships, marriage, kids etc.], but most of us, we just exclude ourselves, just because society tells us, this is not for you.”

“If we do not believe in ourselves, and believe that we have a disability, but we don’t have to limit ourselves because of that. If we do that [the former], we cannot be able to do whatever we want, or we cannot go out there to have a normal life. In order to do that we need to accept ourselves and believe in ourselves first.”

A good self-esteem, and respect for oneself was seen as a protective factor against other challenges.

“So, guys come to me, they just want to have sex with me, and they said let’s have sex and let’s see what will going to happen, like if we’re gonna have a relationship or not, we’ll see after that, but first we’ll have to sleep together. So, I just try to protect myself and avoid this kind of things, because being a person with disability and having something more [than just sex: STDs, psychological effect, pregnancy -things she can’t deal by herself] might be very difficult. So, I just want to know that person first, before I get into any kind of sexual activity with them.”

Majority of the women repeatedly said that they are brave and strong, and encouraged each other not to give up, but to keep on fighting.

“Then, I started to think that I should be very strong and start to stand up for myself.”

To have a disability was seen as a strength, or to give one strength and thus make it easier for one to face challenges. So if one has a negative mindset and does not believe in themselves or their rights, it can cause them more challenges.

“The challenges I faced because of my disability really made me very strong. I think it’s really helpful for me to face those challenges.”

“I think disability selects very strong people as well. And we are very very strong,...both physically and mentally.”

Additionally to the above, the results suggest that the women also make active choices based on their own mindset or thoughts, which also has an impact on the challenges they face. Some women explained that they choose to come and join the coffee meetings at EWDNA for example, because they want to learn more about SRH.

“I get a lot of advantages because I come here. I even get a chance to take cooking training and also get awareness on reproductive health. And also what being a woman with a disability really means. And it gives me confidence to talk out loud.”

“[...]coming here and seeing, meeting different people, and even the association made me very strong. They...encouraged me, so now, it doesn't matter if the situation is comfortable or not, I can manage my life.”

Some women had restrained themselves according to the society's wants and assumptions, because they considered it to be easier for themselves - they did not want to explain themselves to anyone, or to face discrimination. These experiences link especially to the societal challenges, as well as the approachability, and appropriateness concepts.

To conclude, the individual, internalized thoughts WWD had about themselves, that also caused and had effects on their mindset and choices are connected to the approachability concept. The resilience, self-trust and -confidence, among other personal characteristics were seen as powerful and helping WWD to avoid, and/or cope with challenges, in their lives in general, but most importantly in this research context, regarding their access to SRH services. As mentioned, these all contribute to how approachable WWD consider the SRH services to be for them (see also Tefera and van Engen 2016,pp.4,17–19).

9. Ethics

This research has followed the Ethical Principles by the International Federation of Social Workers (IFSW 2018), the Research Ethics by the Social Research Association (2021), and the Code of Ethics by National Association of Social Workers (NASW 2008). Research has multiple stages where ethics play a large role i.e., choosing methods and theories, writing invitation letters, data collection, conducting interviews, interpreting, analyzing, and writing. Ethical considerations are important to keep in mind throughout the process and be transparent and honest about them, in order to add transparency and reliability of the research. There are surely a number of things, situations and scenarios that I have not thought of, and are therefore not discussed in the report.

When doing research it is important to acknowledge the reflexivity of the researcher: I am a master's student in my late 20s, who has studied her bachelor's degree in Finland, and the current master's degree in Sweden. Additionally, I have also been privileged to live in other countries¹⁹.

¹⁹ I have lived and worked in Ireland, done an exchange in the Netherlands, and an internship in Ghana.

One of the most relevant ethical discussions and considerations I had related to this research process was to acknowledge my own position to it. I do not identify myself as a WWD, although I do have a visual impairment and have had some problems with mental health in the past. Both of these can be seen as disabilities by the definition of the CRPD. Despite not identifying as a WWD myself, I have been working closely with people with disabilities for several years. My work has mainly focused on youth with disabilities. I noticed gaps in my client's knowledge on SRH rights, which was the primary encouragement for me to get interested in doing research on this respective topic.

As being a white, euro-centric, Western cis-woman without disability traveling to, and conducting research about WWD, their rights, and challenges accessing SRH services in Ethiopia, it was critical to reflect how my position affects my writing, the research process, my understanding, how I present myself to the FG participants, and to consider and discuss being an insider-outsider (see Rohleder et.al 2019,p.6). I have no prior experience in research, except from my bachelor's thesis. Thus, there has been a lot of new information and learning for me regarding this process. Particularly, I want to mention conducting research in another continent, in multiple languages, that are not my native ones, surrounded by a variety of different religions and cultures, and collaborating together with two different kinds of organizations. I also considered and wondered whether there is something specific that the ODPs might say or leave out - since they can also be understood to be positioned to state certain things. I also asked myself whether we have the same agenda with both of the organizations, could there be a clash of interests, will my study truly help their work as well, and why should I do this, instead of a local student in Ethiopia. It is important to note that Abilis covered my flight tickets back-and-forth to Addis Ababa, as well as a daily compensation to partly cover my costs at site. They also paid for a local WWD to be my assistant and translator. EWDNA contributed financially by covering the costs of the sign language interpretation in the needed FGs.

I did not want my inexperience to hinder or stop me from conducting this research, but rather to learn and gain from it in as many ways possible. Rohleder et.al (2019,p.89) claim that some researchers, new to disability studies, can avoid the topic due to its very wide definitions regarding the group of people it includes, or other possible complexities. They, along with Swartz (2014,p.2) continue saying that any good attempt towards evening out the knowledge gap, and a more inclusive research is useful. Hopefully this research has accomplished that.

10. Discussions on limitations

All research has its limitations. Some of the limitations of this research were time and participant related. The results only present a small glimpse of the lives and challenges of WWD in Ethiopia. The results might have been different if the study had i.e., taken place in another country, city, rural village, or in another time - of the year, in the past or future. Therefore, the results cannot as such be generalized in a wider context. Although, the results are somewhat similar to what the previous literature has presented (see i.e., Tefera and van Engen 2016; see also Chapter 4 in this report). What needs to be held in mind is that the results can be biased: they are presented based on my understanding and focus.

Speaking of time, Ethiopia has a local time of its own, which is different from the internationally used one. The local year in Ethiopia during the FGs was 2014, so eight years behind the international year 2022. Their yearly calendar also has 13 months, compared to the 12 recognised internationally. Additionally to this, they also have their own local time, clockwise. The local time there was six hours ahead of the international time: 2pm was 8pm local time, so there were differences both in time and year. These circumstances created some challenges in arranging the FGs, and are visible in the signed consent letters as signatures and dates in the local time and year. Another reflection on the FGs is that the participants might have discussed differently if I had asked them to sign the consent letter in the beginning. Some participants also might have been more sharing and/or talkative around other participants in other groups, than the ones they were with now.

Other time related limitations include my 3-week-long period in Addis Ababa. If I had stayed for a longer time, I might have been able to familiarize myself more with the women and improve their confidence. There could have also been a different kind of research - instead of FGs, have weekly meetings with a certain group/groups with a certain SRH topic. This way I could have got different, new, more sensitive or private perspectives, thoughts, experiences. Additionally, the thought of the UN Conventions being very “Western”, created and influenced by the global North, and thus possibly not the most accurate, adequate, or appropriate to use in research with people with disabilities in the global South was present in the process.

Sample selection was conducted by having EWDNA helping with the participant selection process. This way of reaching out to participants raised concerns about the members' privacy and

authentic voluntary participation. The women might already be interested in and aware of the topic, or they might feel loyalty towards the organization, and thus feel obligated to participate. The results could also have been different if discussing with members of an organization that barely covers SRH topics. Also, the women were “recruited” from a participation list from the latest coffee ceremony where my assistant had shared information about the research. The sample of this research thus only represents the individuals who happened to be present at this particular meeting. This way possible participants were lost by only contacting women on that list. Due to the fact that I did not call the individuals myself, and did not understand the language spoken, I cannot be totally sure the women actually wanted to participate on their own terms, or if the conversation or the information was (unconsciously, or unknowingly) steered in some way. The participants of this research are not part of the analysis process. This can also be seen as a limitation of research. The participants also represented people with certain types of disabilities or impairments, if these were changed, also the results might look different.

A big limitation of this research is the language barriers. There were four different languages used during the process, and three during the FGs. An important thing to note, is that though the FGs were mainly in Amharic and sign language, the transcriptions are in English. Thus, they fully rely on the translations I got from my assistant during the FGs. Therefore, there can be a loss of potential in-depth experiences, comments, or thoughts. Also, the language I have used in this research can be biased, and/or ableist. Since English is not my native language, and my speech was translated to Amharic, I could also not be 100 percent sure of the nuances of the translations and whether my message would get through the way I hoped. This was an aspect I had to be aware of in advance and take into consideration both during the FGs and while transcribing. Also, the chosen research method had its limitations. The simultaneous talk of the participants was one of them (see Bryman 2012,p.517).

Translations also created other ethical issues. While translating to the participants, the translators sometimes (tried to) explain and “correct”, guide, or lead the answers of the participants by stating i.e., that their comments are not about the topic, “it’s about this, not that”, “do you have something else about the original topic”, “it’s not about feelings, but actual needs” - explaining the topics and answering the participants’ questions themselves, without consulting or asking me first to elaborate or explain. This can have caused distortion in the results.

Another limitation of this research was the two mothers' involvement in the FGs. They joined the discussions with their child who had a disability or impairment. These participants might not have shared as openly as they would have wanted due to their mother's presence. They might have felt that they are being watched, judged or limited somehow. This perspective can be linked to how appropriate the women considered the discussions to be in front of a parent, or vice versa, how appropriate the mother's considered the topics to be asked. The presence of the mothers' can also have been a positive thing - maybe the participants shared as much as they did because they felt more comfortable, safe, and relaxed in familiar company. This can have affected the feeling of approachability towards myself and this research. The contribution of the mothers did increase my own understanding of the context of WWD in Addis Ababa, so it was not useless or unnecessary. Maybe there could have been a separate FG for the parents. The mothers also shared about the experiences of their children, who were present in the FGs. I decided to include those comments in the results, since the topics were openly discussed in the groups and most of the other comments from these two FGs were somehow related to these stories. Also other participants shared stories about other WWD. I decided to include them too because I was not sure whether the women would only say that they talk about other WWD, or if they would simply not want to share the stories as their own.

Regarding the outcomes of this research, the impact on the WWD can be discussed, due to the fact that the paper only fully exists in English. The results will be summarized, translated to Amharic, and sent to EWDNA after grading, but this also means that the participants do not have the opportunity to comment or approve the paper before publication (see Bryman 2012,p.391). In the beginning of the research I asked myself whether Abilis, EWDNA, and I would have the same agenda regarding the research - after the FGs, I ask myself if the participants and I had the same agenda. I received comments such as;

“[...]I hope you will not forget about us when you go back to your home and I'm sure you gonna work collaboratively with the government to work on these problems and to have a better life for women with disability in Ethiopia.”,

which implies that the women may have thought that I work together with the Ethiopian government. Stating and explaining the case more thoroughly to them could have made a difference in the results, increased the trustworthiness of the research, and diminished the possibility of deception (Bryman 2012,p.143).

11. Conclusion

This research aimed at finding out what kind of challenges WWD have accessing SRH services in Addis Ababa, Ethiopia. The research found five different, but interconnected challenges. These were categorized as society, information, and environment -related challenges, financial struggles, and lack of support mechanisms. The challenges were interlinked and affected each other. Mainly, the reasons behind the challenges were pointed out to be the government's inability to respect the conventions it has ratified, and its poor legislative tools and policies, that do not include WWD. Another reason behind part of the challenges was the internalized thoughts that the women had about themselves. The findings of this research have similarities to the presented, previous literature from around the world. It proves the need to act upon the challenges, not only to study and research them.

The results had different aspects that can be placed within some certain models of disabilities. The forceful sterilization, abortion, or other kind of eradication of people with disabilities is connected to the eugenic and medical models. The results also showed that Ethiopia, or at least Addis Ababa, does not have strong or visible human rights or social model understandings of disability. This research has shown that WWD do not have adequate enough access to the SRH services in Addis Ababa and for example lack available sign language interpreters, appropriate support, understanding, respect, and accommodation from the society, as well as financial resources and physically accessible facilities.

I had not expected to find internalized (ableist) thoughts as an outcome. It was though, evident in the majority of the groups, causing the women to hinder themselves from accessing the SRH services. To address this, to enhance the feeling of belonging, inclusion, and worthy, there must be more emphasis on the empowerment of, and building the self-confidence of WWD, but even more importantly to go to the core of the internalized ableism - to educate the surrounding communities and societies about disability in more radical, practical, and concrete ways. These are all areas where social work can be adjusted, even in contexts of it being "only healthcare aspects". One woman recommended that a new disability-inclusive education and awareness-rising needs to start from the children, because they are the future.

"Because the grown-ups already have these kinds of assumptions about what's right or wrong, so we need to work on the coming generations for them to have a better world."

There needs to be more research on the methods and strategies that have worked to fight against the negative assumptions and the attitude of the society, as well as how to, in practice, improve the access to SRH services for WWD. The policies and legislative tools, along with the service provisions, not only in Addis Ababa, but around the country, also need to be planned and implemented with the help of WWD. As the participants mentioned, the healthcare professionals need to have disability and SRH rights included and implemented in the curriculums. The country should learn, and from there change the way it views disability - move forward from a medical, charity, and eugenics perspective to a more human rights, social, and intersectionality-based perspective. Therefore, I recommend and urge Ethiopian organizations, companies, municipalities, and the government to take up on this, and to hear, listen, and see what the women have to say. This should be encouraged by other international actors.

To conclude, the main message, the greatest need, behind the challenges mentioned in this research can be summarized in the following quote:

“So, we want them [the society] to be more acceptable, polite, and understanding.”

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Appendixes

Appendix 1. The Information Letter

Dear letter recipients and members of Ethiopian Women with Disabilities National Association (EWDNA),

Do you identify yourself as an Ethiopian woman with a disability or an impairment? Do you live in Addis Ababa, or neighbouring areas? If yes, I ask you to please pay attention to the following.

I am a Social Work and Human Rights master's student from Gothenburg University, Sweden and I am conducting my master's thesis this year. The title of my thesis is *Challenges women with disabilities face accessing sexual and reproductive health (SRH) services*, and I am looking for participants to join my focus group discussions.

Description of the Research

The purpose of my thesis research is to find out what kind of experiences and possible challenges, if any, women with disabilities face accessing sexual and reproductive health (SRH) services in Addis Ababa, Ethiopia. SRH services in this research are considered as services that i.e., relate to women's health, sex, sexuality, reproductivity, or a mixture of these. Examples of these could among others be family planning, gynaecology appointments, contraceptives, or health education.

This research will be held at Addis Ababa, Ethiopia, and will be carried out by conducting focus group discussions, because I want to find out what women with disabilities themselves have to say about their experiences. The reason being trying to bring some light to the experiences women with disabilities have regarding SRH services.

This thesis is conducted in a collaboration with Ethiopian Women with Disabilities National Association (EWDNA) and Abilis Foundation.

Gathering, Processing, and Sharing the Data

The focus groups will be conducted at EWDNA's facilities in Addis Ababa in early July 2022. The actual times for the focus groups will be decided later together, after my arrival to Addis Ababa. The time spent per focus group depends on the number of participants, possible interpretations and/or accommodations that might be placed. The focus groups will be held in English with local Amharic and Sign language interpreters.

The focus groups will consist of few participants each. The idea is to discuss your experiences of accessing sexual and reproductive health (SRH) services. I will try my best to make the focus groups as safe and comfortable as possible, but it is good to be aware of the possibility of uncomfortable feelings raised by the discussions.

Further, considering the sensitivity of the topic I want to give an opportunity to have a private discussion with me. This is to give a chance to express and share experiences or thoughts that might not be shared with others in the focus group discussions.

The focus groups will be recorded on audio, and hopefully also on video, for research purposes only. This is to help the transcription process, which I will do myself in English.

There is a more specific, separate consent form for persons willing to participate. Should you agree to participate, your consent can be withdrawn at any given time, even if it has already been given, or if one has already participated in the discussions. You also have the right to decline answering any questions or end the discussion from your part at any time without giving an explanation.

The final thesis will be shared to the Ethiopian Women with Disabilities National Association (EWDNA), and Abilis Foundation. The thesis will also be published online in Gothenburg University's publication database.

Confidentiality

The discussions are confidential, and I will only use the gathered information for this research.

The gathered data will be used in this research as anonymous. This means that any identification factors will be removed to prevent that no one can be recognised from the data. Such factors include participant names, specific ages, or individual disabilities or impairments. Anonymous quotes or paraphrases of participant's comments might be included in the thesis. A description of the focus group participants might exist for example in the following, anonymized forms:

“The focus groups had all and all X number of participants, aged between 18-65 years, with a variety of disabilities”

“A woman in their 30s, with a physical disability, shared their experiences...”

The gathered data will be transferred from the audio device to a memory stick. This is where I will keep the transcriptions as well, to avoid the use of internet and thus the possibility of data being hacked or shared online. I am the only one using and working with the data. All the data will be destroyed when the research is finished.

The Ethical Principles of the International Federation of Social Workers (IFSW), the Code of Ethics of the National Association of Social Workers (NASW), and the Ethical Guidelines of the Social Research Association (SRA) are implemented throughout this research.

Risks of the Research

The topic of SRH rights, and services can be considered as a highly sensitive one. The topic might have a potential to trigger or raise a variety of emotions, feelings, memories, or thoughts. In case you feel uncomfortable with the discussion, you have the right to skip the question and not answer, leave the situation for a while or completely and finish it on your part. You do not have to explain these actions or decisions.

Another risk factor is the language barrier – the researcher speaks English, and the participants mostly speak Amharic or use Sign language. There will be interpreters present during the focus groups. Some humane misunderstandings and miscommunication might still occur.

Contact Information

If you are interested in taking part in my thesis research, I would be glad if you could let me know about it in advance. Any questions can be sent to me or my supervisor at any time during the research process.

I am traveling to Addis Ababa in the end of June 2022, I hope to see you then!

Best regards,

Matilda Hertell

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አባሪ 1: የመረጃ ደብዳቤ

የተወደዳችሁ የዚህ ደብዳቤ ተቀባዮችና የኢትዮጵያ አካል ጉዳተኛ ሴቶች ብሔራዊ ማኅበር አባላት ራስዎን እንደ ኢትዮጵያዊት አካል ጉዳተኛ ወይም ስነት ያለባት ሴት ይቆጥራሉን? የሚኖሩት በአዲስ አበባ ወይም አዲስ አበባ አጎራባች አካባቢ ነውን? መልስዎ አዎ ከሆነ፣ በመቀጠል ላለው ትኩረት ሰጥተው እንዲያዳምጡኝ በአክብሮት እጠይቅዎታለሁ።

እኔ በስዊድኑ የጎተንበርግ ዩኒቨርሲቲ የማኅበራዊ አገልግሎትና ሰብአዊ መብት የማስትሬት ዲግሪ ተማሪ ስሆን በዚህ ዓመት የመመረቂያ ጽሑፌን እየሠራሁ ነኝ። የማስትሬት ዲግሪ የመመረቂያ ጽሑፌ ርእስ አካል ጉዳተኛ ሴቶች የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን ለማግኘት የሚገጥሟቸው ተግዳሮቶች የሚል ነው። ለዚህ ጥናቴ የትኩረት ቡድን ውይይት ላይ የሚሳተፉ ፍቃደኞችን እየፈለግሁ ነው።

የምርመራ መግለጫ

የመመረቂያ ጽሑፌ ዓላማ፣ አካል ጉዳተኛ ሴቶች በአዲስ አበባ፣ ኢትዮጵያ የሚሰጡ የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን ለማግኘት ተግዳሮቶች የሚያጋጥሟቸው ከሆነ፣ ምን ዓይነት ልምድ እንዳላቸውና ምን ተግዳሮቶች እንደገጠሟቸው ለመለየት ነው። በዚህ ጥናት የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶች ሲባል ከሴቶች ጤና፣ ጾታዊ ግንኙነት፣ ወሲባዊነት፣ ስነተዋልዶ ጋር የተያያዙ፣ ወይም የእነዚህ ድብልቅ ማለት ነው። ለእነዚህም ምሳሌ የሚሆኑት፣ ከሌሎች በተጨማሪ የቤተሰብ ምጣኔ፣ የማገጸን ህክምና ቀጠሮዎች፣ የወሊድ መከላከያዎች ወይም የጤና ትምህርት አገልግሎቶች ናቸው።

ይህ (ጥናታዊ) ምርመራ የሚካሄደው በአዲስ አበባ፣ ኢትዮጵያ ሲሆን፣ ጥናቱም የሚካሄደው የትኩረት ቡድን ውይይቶችን በማድረግ ነው። ይህም የሚሆንበት ምክንያት አካል ጉዳተኛ ሴቶች ስለራሳቸው ተሞክሮ ምን እንደሚሉ ለማወቅ ስለምፈልግ ነው። አካል ጉዳተኛ ሴቶች የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን በተመለከተ ያሏቸውን ተሞክሮዎች በተመለከተ ምን ምክንያት ለመስጠት እንደሚሞክሩ ለመመርመር/ (ለመረዳት) ነው።

ይህ ጥናታዊ ምርመራ ከኢትዮጵያ አካል ጉዳተኛ ሴቶች ብሔራዊ ማኅበርና ከኤቢሊስ ፋውንዴሽን ጋር በመተባበር የሚሠራ ነው።

መረጃን መሰብሰብ፣ ማስኬድና ማጋራት

የትኩረት ቡድን ውይይቶች በአዲስ አበባ በኢ.አጉ.ሴ.ብማ ቅጥር ግቢ ውስጥ በሀምሌ ወር መጀመሪያ ላይ የሚካሄዱ ይሆናል። የትኩረት ቡድን ውይይቶች የሚካሄድባቸው ትክለኛው ቀናቶች ግን እኔ አዲስ አበባ ስገባ ወደፊት በጋራ የሚወሰን ይሆናል። እያንዳንዱ የቡድን ውይይት የሚወስደው ጊዜ እንደ ቡድኑ አባላት

ብዛት፣ ሊኖር እንደሚችለው የትርጉም አገልግሎት ሁኔታና/ ወይም ሊመቻች እንደሚችለው ተመጣጣኝ የማመቻቸት ስራ የሚወሰን ይሆናል። የትኩረት ቡድን ውይይቶች በእንግሊዝኛ ቋንቋ የሚካሄዱ ሲሆን በአገሩ ቋንቋ በአማርኛና በምልክት ቋንቋ ተርጓሚዎች የሚታገዙ ይሆናል።

እያንዳንዱ የትኩረት ቡድን የተወሰኑ ተሳታፊዎችን ብቻ የያዘ ይሆናል። ሀሳቡም እናንተ የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን ለማግኘት ያጋጠሟችሁን ተሞክሮዎች ለመወያየት ይሆናል። በተቻለኝ አቅም ሁሉ የቡድን ውይይቶችን ለእናንተ ምቹና አስተማማኝ ለማድረግ ጥረት አደርጋለሁ። ይሁን እንጂ በውይይቱ ወቅት ምቹ ያልሆኑ ስሜቶች ሊነሱ የሚችሉበት ሁኔታም ሊፈጠር እንደሚችል ከግንዛቤ ማስገባት መልካም ነው።

በተጨማሪም፣ የርእሰ ጉዳዩን ስሜት ነኪነት ከግምት ውስጥ በማስገባት ከእኔ ጋር የአንድ ለአንድ የግል ውይይት እድል ለመፍጠርም እፈልጋለሁ። ይህም በቡድን ውይይት ጊዜ ከሌሎች ጋር ለማጋራት የማይፈለጉ የግል ተሞክሮዎችን ወይም እሳቤዎችን ለመግለጽና ለማጋራት የሚችሉበት እድል ለመፍጠር ነው። የቡድን ውይይቶች በመቅረጻ ድምጽ የሚቀዱና ምናልባትም በሺዲዮም የሚቀረጹ ይሆናል፤ ይህም የሚውለው ለጥናታዊ ምርምር ሥራው ዓላማ ብቻ ነው። ይህም፣ እኔ ራሴ በእንግሊዝኛ የምሰራውን ወደ ጽሑፍ የመቀየር ሥራውን ለመደገፍ እንዲያስችለኝ ነው።

በጥናቱ ለመሳተፍ ፍቃደኛ የሆኑ ሰዎች በተናጠል የሚፈረሙት ራሱን የቻለ የስምምነት ቅጽ አለ። ለመሳተፍ ፍቃደኛ ቢሆኑም፣ ፍቃድዎን በማንኛውም ሰአት ሊያነሱ ይችላሉ፤ ምንም እንኳን ፍቃደኝነትዎን የሰጡና በውይይቱ የተሳተፉ ቢሆንም ሀሳብዎን ለመቀየር ይችላሉ። በተጨማሪም፣ ማንኛውንም ጥያቄ አለመመለስ ወይም በእርስዎ በኩል ውይይቱን በማንኛውም ሰአት ያለምንም ማብራሪያ ለማቋረጥ ይችላሉ።

የመጨረሻው የምርምሩ ቅጽ ለኢትዮጵያ አካል ጉዳተኛ ሴቶች ብሔራዊ ማኅበር (ኢ.አጉ.ሴ.ብማ) የሚጋራ ይሆናል። የመመረቂያ ጽሑፍ በጎተንበር ዩኒቨርሲቲ የመረጃ ማጠራቀሚያ ላይም ሊታተምና በአንላይን ሊገኝ ይችል ይሆናል።

ምስጢራዊነት

ውይይቶች ምስጢራዊ ናቸው። የተሰበሰቡትን መረጃዎች ለምርምር ስራው ብቻ የምጠቀምባቸው ነው የሚሆነው።

የተሰበሰበው መረጃም የምንጩ ማንነት ሳይገለጽ በጥቅም ላይ ይውላል። ይህም ማለት ከመረጃው በመነሳት የመረጃ ሰጪዎች ማንነት እንዳይታወቅ ለማድረግ የመረጃ ሰጪዎችን ማንነት ሊለዩ የሚችሉ ገለጻዎች በሙሉ ይወገዳሉ። እነዚህም ገላጮች የተሳታፊዎች ስም፣ እድሜ፣ የግለሰቧ የጉዳት ዓይነት ወይም ስነት አይገለጹም። የተሳታፊዎቹ አስተያየቶች፣ ጥቅሶች፣ አጽንኦተ ንግግሮች የተናጋሪዎ ማንነት በማይታወቅበት ሁኔታ በመመረቂያ ጽሑፍ ውስጥ ሊካተቱ ይችላሉ። የትኩረት ቡድኑ የተሳታፊዎች ማንነት በማይታወቅበት ሁኔታ በሚከተለው ምሳሌ መልክ ተገልጸው ሊቀርቡ ይችላሉ፡

“የትኩረት ቡድኖቹ በአጠቃላይ ተሳታፊዎች ብዛት... ሲሆን የእድሜ ክልላቸውም ከ18-65 ዓመት ነው። የተለያዩ አካል ጉዳት ዓይነቶችንም ያካተቱ ናቸው።”
“በ30 ዎቹ ዓመታት የእድሜ ክልል የምትገኝ፣ አካላዊ የአካል ጉዳት ያለባት ሴት፣ ተሞክሮዋን እንዳካፈለችን.... ”

የተሰበሰበው መረጃም ከመቅረጻ ድምጽ ወደ ሚሞሪ ስቲክ ይቀየራል። ይህም ወደ ጽሑፍ የለወጥኳቸውን መረጃዎች ሁሉ የማጠራቅምበት ቦታ ነው። ይህንንም የማደርገው ኢንተርኔት በመጠቀም ሊያጋጥም የሚችለውን የመረጃ መዘረፍና ወይም በአንላይ ማጋራትን ለመከላከል ነው። በመረጃው የምጠቀመውና የምሰራበት ብቸኛ ሰው እኔ ብቻ ነኝ። የመመረቂያ ጽሑፌን ዝግጅት ካጠናቀቅሁ በኋላ መረጃዎቼን በሙሉ የማስወግዳቸው ይሆናል።

የዓለም አቀፍ ማገበራዊ አገልግሎት ባለሞያዎች ፌዴሬሽን የስነምግባር መመሪያዎች፣ የብሔራዊ ማገበራዊ አገልግሎት ባለሞያዎች ማገበሪያ የስነምግባር መመሪያና የማገበራዊ ምርምር ማገበሪያ የስነምግባር መመሪያዎች ይህ የምርምር ሥራ በሚሠራበት ጊዜ ሁሉ ይተገበራሉ።

የምርምር ስጋቶች

የስነጽታና ሥነተዋልዶ ጤና መብቶችና አገልግሎቶች የሚለው ርዕሰ ጉዳይ በጣም ስሜት ነኪ ከሆኑ አርስቶች መካከል እንደሆነ ከግምት ውስጥ ይገባል። ርእሱ የተለያዩ ምላሾችን፣ ስሜቶችን፣ ትውስታዎችን፣ ወይም እሳቤዎችን የመቀስቀስ ወይም የማነቃቃት አቅም ሊኖረው ይችላል። ምናልባት በውይይቱ መካከል ጥሩ ስሜት ካልተሰማዎት፣ ጥያቄውን የማለፍ ወይም መልስ ያለመስጠት መብት አለዎት። ለጊዜው ወይም ሙሉ በሙሉ ራስዎን ከሁኔታው ሊያርቁና ስሜትዎን ሊያሳልፉ ይችላሉ። እነዚህን ድርጊቶችና ውሳኔዎች መግለጽ አይጠበቅብዎትም።

ሌላው ስጋት የቋንቋ መሰናክል ነው- የጥናት ተመራማሪዎች እንግሊዝኛ ተናጋሪ ናቸው፣ የጥናቱ ተሳታፊዎች ደግሞ በአብዛኛው አማርኛ ይናገራሉ ወይም የምልክት ቋንቋ ይጠቀማሉ። በቡድን ውይይቱ ጊዜ ተርጓሚዎች ይኖራሉ። ቢሆንም አንዳንድ ሰብአዊ አለመግባባቶች ወይም የተግባባት ችግሮች ሊያጋጥሙ ይችላሉ።

የመገኛ አድራሻ መረጃ

በመመረቂያ ጽሑፌ ጥናት ለመሳተፍ ፍቃደኛ ከሆኑ አስቀድመው ፍቃደኛነትዎን ቢያሳውቁኝ ደስ ይለኛል። ማናቸውንም ዓይነት ጥያቄዎች በማንኛውም ጥናቱ በሚካሄድበት ጊዜ ለእኔ ወይም ለተቆጣጣሪዬ ሊልኩልን ይችላሉ።

እኔ በሰኔ ወር 2022 መጨረሻ ላይ ወደ አዲስ አበባ እጓዛለሁ እና የዛን ግዜ እንገናኛለን ብዬ ተስፋ አድርጋለሁ!

መልካም ጊዜ!

ማቲያ ቪርተል

የማኅበራዊ አገልግሎትና ሰብአዊ መብቶች
የማስተርስ ተማሪ

ጎተንበርግ ዩኒቨርሲቲ፣ ስዊድን
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ማርኩስ ኸርዝ

የጥናታዊ ጽሁፍ አማካሪ፣ ከፍተኛ መምህር
የማኅበራዊ አገልግሎት ትምህርት ክፍል

ጎተንበርግ ዩኒቨርሲቲ፣ ስዊድን
marcus.herz@gu.se

Appendix 2. The Letter of Consent

If written consent is not applicable to you, please inform me about it – an oral consent can be accepted if it is recorded on tape.

- I have had the opportunity to familiarise myself with the Information Letter in either English, Amharic, or Sign language.
- I have understood the information presented in the Information Letter.
- I have had the opportunity to consider the information and my participation.
- I have had the opportunity to ask questions and get answers to them.
- I have understood that my participation in this research is voluntary.
- I have understood that I am free to withdraw my participation and consent at any time without having to explain or reason it to anyone.
- I am of full age (above 18 years old).
- I agree to be recorded for research purposes only.
- I understand that experiences I share in the focus group or individual discussions may be used in the master's thesis.
- I understand that the thesis is written in English, and there is a risk of language misinterpretations both ways.

The following three options are additional. Please tick the box **ONLY** if you agree.

- I give my consent to share the collected information to Abilis for further actions
(Like publications or research).

If my age, disability, or impairment are mentioned during the interviews,

- My age group can be mentioned in the thesis.
- The kind of disability or impairment I have can be mentioned in the thesis.

By signing this document, I give my consent to the above-mentioned causes.

Date and location _____

Name of participant _____

አባሪ 2. የስምምነት ደብዳቤ

የተጻፈው ስምምነት ለእርስዎ የማይሰራ ከሆነ፣ እባክዎ ይህንኑ ለእኔ ያሳውቁኝ፤ በቴፕ ከተቀረጸ የቃል ስምምነትም ተቀባይነት ይኖረዋል።

- የመረጃ ደብዳቤውን በእንግሊዝኛ፣ በአማርኛ ወይም በምልክት ቋንቋ ለመረዳት የምችልበት እድል አግኝቻለሁ።
- በመረጃ ደብዳቤው ላይ የቀረበውን መረጃ ተረድቻለሁ፤
- የምሰጠውን መረጃና የተሳትፎዬን አስፈላጊነት በተመለከተ ለማገናዘብ እድል አግኝቼ ነበር።
- ጥያቄዎችን ለመጠየቅና መልስ ለማግኘት እድል አግኝቼ ነበር።
- በዚህ ምርምር የምሳተፈው በበጎ ፍቃደኝነት መሆኑን ተረድቻለሁ።
- ምንም ዓይነት ማብራሪያ ወይም ምክንያት ሳላቀርብ በምርምሩ የማደርገውን ተሳትፎ ለማቋረጥ ወይም የሰጠሁትን ስምምነት በማንኛውም ሰአት ለማንሳት ነጻነቴ እንዳለኝ ተረድቻለሁ።
- በሙሉ እድሜ ላይ እገኛለሁ (18 ዓመትና በላይ)፤
- ለምርምሩ ዓላማ ብቻ እንድቀረጽ ተስማምቻለሁ፤
- በቡድን ወይም በግል ውይይት የማጋራቸው ተሞክሮዎች ለሁለተኛ ዲግሪ ማሟያ ጽሑፍ ጥቅም ላይ ሊውሉ እንደሚችሉም ተረድቻለሁ።
- የመመረቂያ ጽሑፍ በእንግሊዝኛ ቋንቋ እንደሚጻፍና በሁለቱም በኩል የቋንቋ ትርጉም መዘባት ስጋት ሊያጋጥም እንደማችል እረዳለሁ።

የሚከተሉት ሰነድ አማራጮች ተጨማሪ ናቸው። የሚስማሙ ከሆነ **ብቻ** ሳጥኑ ውስጥ ምልክት ያድርጉ፡-

- የሰጠሁትን መረጃ አቢሊስ ለተጨማሪ ጥቅም ማዋል ይችላል(ለማሳተም፣ለጥናት ወዘተ)

እድሜዬ፣ የአካል ጉዳቴ ወይም ጉዳቴ በመጠይቁ ጊዜ የሚጠቀሱ ከሆነ፣

- የእድሜ ክልሌ በመመረቂያ ጽሑፍ መጠቀስ ይችላል።
- የጉዳቴ ዓይነት ወይም ጉዳቴ በመመረቂያ ጽሑፍ መጠቀስ ይችላል።

ይህንን ሰነድ በመፈረም፣ ከላይ ለተገለጹ ቅድመ ሁኔታዎች ፍቃዴን ሰጥቻለሁ።

ቀንና ቦታ _____

የተሳታፊ ስም _____

Appendix 3. The focus group discussion guideline

1. Would you like to share something about yourself and your everyday life?
2. In your own experience, how, if at all, does your disability affect your
 - everyday life?
 - overall health?
 - relationships with other people?
 - possibility to work or study?
3. Would you like to share your views on sexual and reproductive health (SRH) rights?
4. What kind of needs do women with disabilities have related to SRH rights and services?
5. What kind of SRH services do you know for women with disabilities?
6. What kind of experiences, and (possible) challenges have you had related to accessing SRH services?
7. What do you think are the causes for these (possible) challenges? In your opinion,
 - why do these challenges exist?
 - do the same challenges exist in all Ethiopia, or to all women with disabilities?
 - have the challenges changed during your lifetime?
 - is there a challenge that is more serious than others?
8. In your opinion, what, if anything, should be changed to improve the accessibility of the SRH services for women with disabilities?
9. What, if any, of EWDNA's workshops, seminars, events, or other work have you taken part in?
10. How have you experienced EWDNA's work?
11. Regarding SRH rights and services, what kind of projects or activities would you like EWDNA, or similar actors, to have or organize? Why?
12. Are you familiar with Abilis foundation?
13. Can you mention EWDNA's projects or activities that Abilis has funded?
14. Have you taken part in Abilis-funded projects or activities?
15. What kind of projects for women with disabilities would you want Abilis, or other similar actors, to fund?
16. Other comments and thoughts.

አባሪ 3. በከፊል የተዋቀረ የትኩረት ቡድን መመሪያ

1. ስለራስዎና ስለእለት ተእለት ሕይወትዎ የሆነ ሊያጋሩን የሚችሉት ነገር ይኖራል?
2. በራስዎ ተሞክሮ፣ ምናልባት አካል ጉዳተኝነትዎ ተጽእኖ አድርጎብዎት ከሆነ፣ እንዴትና በምን መልኩ ነው?
 - በእለት ተእለት ሕይወትዎ?
 - በአጠቃላይ ጤናዎ?
 - ከሌሎች ሰዎች ጋር በሚኖርዎ ግንኙነት?
 - የመስራት ወይም የመማር እድል?
3. ስለስርዓተ ጾታና ስነተዋልዶ ጤና መብቶች ያለዎትን አመለካከት ሊያጋሩኝ ይችላሉን?
4. የስርዓተ ጾታና ስነተዋልዶ ጤና መብቶችና አገልግሎቶች ጋር በተያያዘ አካል ጉዳተኛ ሴቶች ምን ዓይነት ፍላጎቶች አሏቸው?
5. ለአካል ጉዳተኛ ሴቶች ምን ዓይነት የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን ያውቃሉ?
6. የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶች ጋር በተያያዘ ምን ዓይነት ተሞክሮዎችና ተግዳሮቶች (ሊያጋጥሙ የሚችሉ ተግዳሮቶች) አሉዎት?
7. የእነዚህ ተግዳሮቶች (ሊያጋጥሙ የሚችሉ ተግዳሮቶች) መንስኤዎች ምንድናቸው ብለው ያስባሉ?

በእርስዎ አመለካከት፤

 - እነዚህ ተግዳሮቶች ለምን ሊኖሩ ቻሉ?
 - ተመሳሳይ ተግዳሮቶች በሁሉም ኢትዮጵያውስጥ ይኖራሉን? ወይም ሁሉንም አካል ጉዳተኛ ሴቶች ያጋጥማሉን?
 - በእርስዎ የህይወት ዘመን ተግዳሮቶች ተለውጠዋልን?
 - ከተግዳሮቶቹ መካከል ከሌሎቹ የበለጠ አሳሳቢ የሚባል አለን?
8. በእርስዎ አስተሳሰብ፣ የአካል ጉዳተኛ ሴቶችን የስርዓተ ጾታና ስነተዋልዶ ጤና አገልግሎቶችን ተደራሽነት ለማሻሻል አስፈላጊ ከሆነ ምን መለወጥ አለበት ይላሉ?
9. ከኢ.አጉ.ሴ.ብማ ባዘጋጀቻቸው (ተሳትፈው የሚያውቁ ከሆነ) በየትኞች ዐውደ ጥናቶች፣ ሴሚናሮች፣ ሁነቶች ወይም ሌሎች ሥራዎች ላይ ተሳትፈው ያውቃሉ?
10. የኢ.አጉ.ሴ.ብማ ሥራዎችን እንዴት ይገልጹዎቸዋል?

11. የስርዓተ ጾታና ስነተዋልዶ ጤና መብቶችና አገልግሎቶችን በሚመለከት፣ ኢ.አጉ.ሴ.ብማ፣ ወይም ሌሎች ተመሳሳይ ተዋናዮች ምን ዓይነት ፕሮጀክቶችና ተግባራትን ማዘጋጀት ይኖርባቸዋል? ለምን?
12. ኤቢሊስ ፋውንዴሽንን ያውቁታልን?
13. ኤቢሊስ የገንዘብ ድጋፍ ያደረገባቸው የኢ.አጉ.ሴ.ብማ ፕሮጀክቶችን ወይም ሥራዎችን ሊጠቅሱ ይችላሉን?
14. በኤቢሊስ የገንዘብ ድጋፍ በተደረገላቸው ፕሮጀክቶች ወይም ሥራዎች ተሳትፈው ያውቃሉን?
15. ኤቢሊስ ወይም ሌላ ተመሳሳይ አካል፣ የገንዘብ ድጋፍ ቢያደርጉላቸው የሚሏቸው ምን ዓይነት የአካል ጉዳተኛ ሴቶች ፕሮጀክቶች ናቸው?
16. ተጨማሪ ሀሳብ እና አስተያየት ካሎት