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Health Care Providers' Attitudes Towards Pregnant Women with Disability at Selected Governmental Hospitals in Cape Coast Metropolis

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Abstract
This paper examined the attitude of healthcare providers towards pregnant women with disability. The study employed concurrent mixed analytical procedure where both quantitative and qualitative approaches were employed. The paper used questionnaire and interview guide to collect the data. The study used a multi-stage sampling technique and operationalised using was cluster, stratified and simple random sampling techniques. A sample size of 170 healthcare professionals was used for the data collection while 10 expectant mothers with disabilities were used for the interview. 149 questionnaires were received and coded representing 86.47% response rate. The non-numerical data were analysed using content and thematic analysis. Analysis of variance (ANOVA) statistics was used to compare mean attitude scale score and interaction of background, exposure variables and professional status. Mean comparison and statistical significant was assessed using ANOVA statistics to understand the association between variables. It was found that although the healthcare professionals have often been dealing with expectant mothers with disabilities, they have very little training and the positive attitudinal value for women with disabilities is weak. Majority of the expectant mothers with disabilities had bad experiences with healthcare professionals. It is recommended that the curriculum for training healthcare professionals especially the nurses and midwives should adequately cater for how to manage cases of women with disabilities.
Keywords: Women with Disability, Healthcare Professionals, Healthcare, Maternal Healthcare and Expectant Mothers with Disabilities
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1. Introduction

People with disabilities (physical, sensory which could be deaf and blindness, intellectual and even mental health impairments), often face negative attitudinal barriers within society in general and from healthcare providers in particular while seeking maternal healthcare services (Kellogg, Slattery, Hudgins & Ormond, 2014). The attitudes and behaviour of healthcare providers obviously have a significant influence on many aspects of care. Negative attitudes of providers may discourage the use of services by the users with disabilities, and negative attitudes may foster low expectations, encourage discriminatory behaviours and marginalization of people with disabilities among health providers themselves (Redshaw, Malouf, Gao & Gray, 2013).

The problem of disability has become more pronounced in modern healthcare because the world over, it has been estimated that more than 1 billion people have some form of disability (Holcombe, 2018). However, among this large number of disability, the prevalence of pregnant women with disability is in the increase including intellectual disability (Castell & Kroese, 2016). These individuals form a greater part of the most marginalised and socially excluded groups in developing countries including Ghana. However, one of the pivotal items on the sustainable development goal agenda is the achievement of universal health coverage.

In fact, section 3.2 of the Sustainable Development Goal (SDG) proposes to have by 2030, end preventable death of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortalities to a least a low as 25 per 1,000 live births (O. D. D. S. 2015). To achieve this important feat, pregnant women of all sort including those with disability should be treated equally without any bias and prejudice. Additionally, the attitude of healthcare providers towards the care of pregnant women with disability should be devoid of any malice or discrimination.

Apparently, quality of care is one of the common problems reported by both women with disabilities and without disabilities. Admittedly, this is largely related to provider's attitude and behaviours that often discourages women from seeking maternal healthcare services. It is well documented in the literature that women's perception of quality of care through previous experience during pregnancy to be a key factor in decision making in regards to seeking care subsequently (Greenwood & Wilkinson, 2013; Kellogg et al 2014; Raju, Mercer, Burchfield, & Joseph 2014). This demonstrates that maternal care to women with disabilities is bedeviled with challenges, majority of which is attributed to poor attitude from the healthcare providers. However, as earlier indicated, these pregnant women with disability also fall within the parameters of universal

healthcare spearheaded by the SGD. It is therefore incumbent on the health services sector and the health administration to implement policies that would make maternal healthcare workers to extend the same attitude and care as meted out to women without disabilities also to those with disabilities.

Such care is very imperative especially in Ghana. This is because Ghana is a signatory to the United Nations' Convention on the Rights of Persons with Disabilities (Ganle, Otupiri, Obeng, Edusie, Ankomah, & Adanu, 2016). In view of this the country has enacted an Act (Act 715) to protect the right of people with disability. Although, widespread implementation and enforcement of the act is yet to be reported, the Act guarantees persons with disability the right to access the same or specialized range, quality and standard of healthcare as provided to other persons, including those in the area of maternal healthcare (i.e pregnant women). Over the period much works have been executed within the general confinement of disability with little emphasis on pregnant women with disability.

Information within existing literature, illustrates that people with disabilities often experiences barriers to health services due to provider's inappropriate attitudes and behaviours (Mitra, Long-Bellil, Iezzoni, Smeltzer, & Smith, 2016). Measuring attitudes of health providers towards disability is important to understanding their perception so that training for health professionals can be improved in order to foster positive views. Additionally, better understanding of the complex relationship between, knowledge, attitude and behaviours would help policy planners to design intervention strategies to change attitudes of healthcare providers towards the person with disabilities and improve healthcare services to those vulnerable groups. The focus of the current paper is to examine the attitude of healthcare providers towards pregnant women with disability.

2. Literature Review

Disability has been defined as the consequence of an impairment that may be physical, mental, cognitive, sensory, emotional, developmental, or some combination of these that result in restrictions on an individual's ability to participate in what is considered as normal in their everyday society (Greenwood & Wilkinson, 2013). Globally, it has been estimated that persons with disability constitute 15% of the world's population. Although the United Nations' Convention on the Rights of Persons with Disabilities guarantees persons with disabilities the same level of right to access quality and affordable healthcare, including maternal healthcare services, as persons without disability (Ganle, 2015), such persons are still one of the most marginalised and socially excluded groups in many countries including Ghana (Mprah, Anafi & Sekyere 2014).

Attitude is defined as the combination of beliefs and feelings held by the individual that predisposes the person to behave in a certain way. It comprises affective, cognitive and behavioural components. Greenwood and Wilkinson, (2013) and Mitra et al (2016) describe attitude in a manner which shows there is a relationship between people's attitude, their knowledge and behaviour (Kellogg et al, 2014; Mprah et al, 2014). Such relationship has been explained diagrammatically as it could be observed in figure 1.

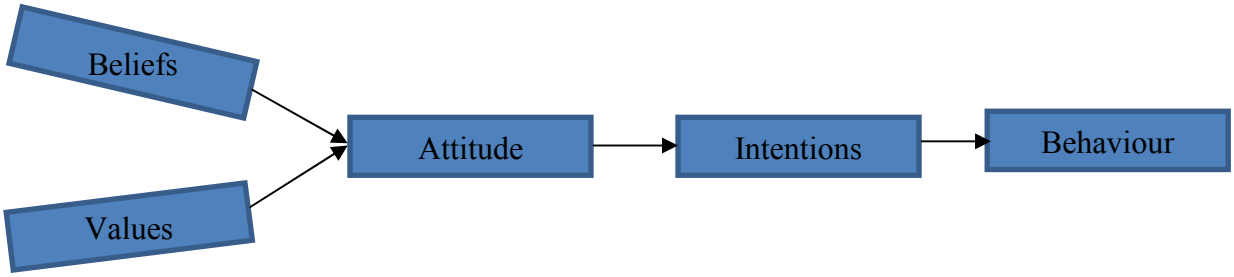

Figure 1: Interrelationship between attitude, beliefs and behaviour

Figure 1 demonstrates in conjunction with the explanations by Mprah et al (2014) that peoples' attitudes are affected by values and beliefs. Afterwards, such attitude then dictates the intentions and behaviour of same people.

The role of direct experience is found particularly important in attitude formation (Ganle, 2015; Redshaw, et al 2013). As earlier explained attitudes are influenced by the individual's experience combined with positive or negative reinforcement. Attitudes and behaviour are linked; however, attitude is only one factor, social norms and group pressure also influence individual behaviour. Negative attitudes and behaviour come from people not having adequate knowledge as well as negative social norms and group pressure. Demographic factors such as sex, age also influence people's attitudes. In Ghana, people with disability are mostly marginalised and neglected. Some are also of the view that disabled individuals have some bad omen and so people tend not to get and offer the necessary help that people with disability need. The belief that disabled people have bad omen could affect the attitude of healthcare workers to pregnant women with disability.

In recent literature, a series of studies, primarily from high-income countries have compared the attitudes of health professionals across professions and between professionals and students on disability. For example, Kpobi and Swartz (2019) conducted a study to compare attitudes among nurses, physiotherapy and occupational

therapy students. The study revealed that nurses held the least positive attitude towards disability, while occupational therapy students showed the most positive attitudes. Other studies have also demonstrated personal attributes influencing attitudes towards disability; however, the findings reported are inconsistent. For instance, women held more positive attitudes than men in other studies (Akasreku, Habib & Ankomah, 2018; Abdul Karimu, 2017).

Additionally, other studies have report mixed findings on the correlation between age of health professionals and attitude towards people with disability. Sakeah, Doctor, McCloskey Bernstein Yeboah-Antwi & Mills, (2014) found an inverse correlation between age of health professionals and their attitude score (Akasreku et al 2018; Raju et al, 2014; Redshaw et al, 2013) while some other studies showed adverse results (Mannava, Durrant, Fisher, Chersich & Luchters, 2015). In addition, the most influential factor in the formation of attitude was reported to be the intensity of exposure and contact with the person with disabilities (Iezzoni, 2011).

Moreover, misconceptions about disability held by healthcare providers have been ascribed as the key issue contributing to provider's negative attitude which is a formidable barrier to healthcare services by women with disabilities (Akasreku et al 2018; Raju et al, 2014; Redshaw et al, 2013). These attitudes and misconceptions are often subtle for which the absence of comprehensive studies into it would make it difficult to find antidote myriad of problems faced by people living with disability. For example, women with disabilities may not be asked about contraceptives. Furthermore, due to the misconceptions on the sexual activeness of people with disability, healthcare providers might defer a pelvic exam (Mannava et al, 2015).

In Ghana for instance, though mental health institutions, exist, most of the curriculum do not tackle how healthcare workers should handle people with disability. Studies show that while some medical schools in high-income countries are now including disability issues in curricula to improve student's knowledge, attitude and skills in disability care, it is still not a priority (Iezzoni, 2011; Sakeah et al, 2014).

Over the past few decades, the Ghana health sector has made good progress in maternal health indicators. For example, reduction of maternal mortality rate from 850 in 1990 to 190 in 2017 as statistically reported by the Ghana health services (Sakeah, et al 2014). Various policies like free maternal care and other maternal policies aimed at reducing maternal mortality rate. However, improvements in these indicators among marginalized population such as women with disabilities are still lower than the general population (Ahumuza et al, 2014). As in many low and middle-income countries, Ghana's healthcare professionals including community health volunteers are the key to providing information and delivery of preventive, clinical and rehabilitative services for all people in the community as well as in health facility settings (Abdul Karimu, 2017). However, disability related problems have not attracted policy planners' attention and there has been no systematic training of healthcare providers in disability care and management. It can be speculated that the continuing poorer results among people with disabilities may reflect inadequate knowledge, misconception and negative attitudes of healthcare providers towards disability.

3. Methodology

This part of the paper provides discussions of relevant methods employed in this investigation. The discussions are structured in thematic areas. The detailed discussions are as follows:

3.1 Study settings

The study was conducted in some selected government hospitals in the Cape Coast metropolis between February to March 2019. The metropolis has one teaching hospital, one university hospital, one mental hospital, and three district hospitals. These hospitals have healthcare workers of which some are community healthcare workers, nurses and midwives. Though there are other private health facilities and other health post normally referred as chip compound within the metropolis the attention of the study was directed at the government hospitals.

3.2 Study design

The study used a simultaneous mixed method approach by which the quantitative and qualitative
data were collected at the same time and analysed simultaneously. An attitude survey among maternal healthcare providers along with qualitative interviews with service users was conducted to examine health service provider's attitudes towards people with disabilities.

3.3 Sample and sampling procedure

The government hospitals in the metropolis was divided into two sections. The elite area based hospitals and the non-elite area based hospitals. There were two facilities from the elite based hospitals and three from the non-elite area based hospitals. 170 healthcare providers specifically nurses and midwives were selected following the criteria recommended by Turner, Angeles, Tsui, Wilkinson and Magnani, (2001) for health facility (HF) surveys. To provide additional insight, a small series of in-depth qualitative interviews were undertaken with ten women

with disabilities aged seventeen to forty-five years who had received maternal healthcare service within the last three years. All healthcare providers and women approached accepted to participate in the study.

3.4 Data Collection Procedure

A tool called Attitude Towards Disabled Person (ATDP) developed in 1960 by Yuker, Block, and Campbell was used to measure healthcare provider's attitude. This tool consists of 30-items with a six rating likert-type scales. The tool's reliability coefficient range is estimated as 0.71 to 0.83 (Akasreku,et al 2014). The reason for the selection of this tools is simplicity, easy to administer, simple to score and the fact that it has been extensively used in previous research to assess general attitudes towards disabled people (Iezzoni, 2011; Raju et al, 2014; Redshaw et al, 2013; Sakeah et al, 2014). Concerning the interviews, an interview schedule (topic guide) was developed and used for the qualitative interviews. All forms were checked after completion of interviews; any found incomplete or with entry errors were identified and participants revisited to complete or confirm the information. The study called for the help of research assistants to conduct the qualitative interviews. All qualitative interviews were audio recorded with participant's permission. The construct validity of the survey instrument was checked using 'Known group technique' comparing group scores and Cronbach's Alpha confirmed the internal consistency reliability (Ganle et al, 2016). For the trustworthiness and confirmability of qualitative data (recording, notes, transcripts), consistency in the process of inquiry, documentation in a reflexive way with a detailed account of the research process and field presentation were followed.

3.5 Measurement of the Attitudinal Tool

The provider's ATDP score was the outcome variable for the attitude survey. A list of statement items was read aloud with which the providers expressed agreement or disagreement with each item statement. The participant's reaction was measured in a response category ranging from +3 to indicate "I agree very much" to −3 to indicate "I disagree very much". The scale did not have a neutral or zero rating point, forcing participants to make either positive or negative response. The ATDP score was categorized on a range from 0 to 180. The score interpretation was based on individual's perceived similarity or differences between persons with and persons without disabilities. A higher score demonstrates perceiving a person with disabilities as the same as a person without disabilities while a lower score signifies that the respondent perceives persons with disabilities as different from persons without disabilities. Following the roadmap of Mitra et al 2016, a higher score was also interpreted as an individual displaying a more accepting (positive) attitude towards persons with disabilities. Similarly, a lower scores reflect rejection or unfriendly attitude towards persons with disabilities. Since there is no consensus in the literature about what threshold is regarded as a positive score the study adopted scores of 110 for male and 113 for female as thresholds using the example of Devkota, Murray, Kett and Groce, (2017).

3.6 Data Analysis

Findings presented are from 170 survey of healthcare providers and ten qualitative interviews of women with disabilities. The survey data was checked for accuracy and completeness and then entered into SPSS (version 22.0 for Windows) for analysis. Data was then cleaned running frequencies and tabulation and crosschecked for consistency, tallying with the related items. Analysis of variance (ANOVA) statistics was used to compare mean attitude scale score and interaction of background, exposure variables and professional status. Mean comparison and statistical significant was assessed using ANOVA statistics to understand the association between variables. The association was considered significant with $P < 0.05$.

The audio-recorded qualitative interviews were transcribed verbatim from the local Fante language and then translated into English. Data were coded and analyzed adopting a grounded theory approach which is the thematic and content analysis which helped identified concepts and categories. These themes were then grouped into categories and later analyzed. Various quotes were selected and presented to represent the themes mentioned. The quantitative and qualitative findings were summarized to produce the conclusions and recommendations.

4. Results and Discussions

This section of the paper applies the techniques, methods and procedures explained under the methodology section. The results from employing the adopted methods are reported and discussed in this section. Table 1 shows selected characteristics of healthcare providers who responded to the ATDP survey. Out of the 170 sampled, 149 of the providers participated in this survey, and the findings have been collated into three groups based on their role and likely contact with pregnant women with disability. Of these, reflecting the general distribution of healthcare providers in the area, more than half (67.1%) were female nurses and midwives (n = 100) who were the first contact in providing maternal healthcare service in Ghana health delivery system. Moreover, 19.5% (n = 29) were auxiliary nurse or what is commonly called community health nurses (CHN). The remaining 13.4% (n = 20) were other health workers (Physician assistants (PA) and doctors) who provide more general medical care, including maternal care. It could also be observed that majority 83.9% (n = 125) of

the respondents were females while the remaining of the 16.1% (n = 24) were males. The majority (77.9%) of the providers were from the non-elite area based hospitals (n = 116), which consist of hospitals other than the university hospital and the teaching hospital. 22.1% (n = 33) participants' elite area based hospital. By age, the largest number of providers (85.9%) were between 25 and 54 years (n = 128), with a small portion (6.0%) below 25 (n = 9), and 8.1% (n = 12) above 54. The age of respondents ranged between 18 and 60 years and the mean age was 40

Table 1 Background characteristics of respondents

Background characteristics	Frequency	Percentage
Location		
Elite area based hospital	33	22.1
Non- elite area based hospital	116	77.9
Gender		
Females	125	83.9
Males	24	16.1
Age		
18-24	9	6.0
25-34	40	26.9
35-44	55	36.9
45- 54	33	22.1
55-60	12	8.1
Midwives	70	47.0
General Nurses	30	20.1
Community health Assistant	29	19.5
Doctors and physician assistants	20	13.4

Analysis of survey results

Table 2 ATDP scores based on profession

Providers' type	Number	Mean	SD	Range
All	149	68	13.75	38-127
Midwives	70	82.55	14.11	44-11
General nurses & community health Assistant	59	85.59	13.45	56-127
Doctors and Physician Assistant	20	73.75	13.02	38-108

From Table 2 The overall ATDP mean score obtained by the respondents was 68.52 (SD = 13.75) ranging from a minimum score of 38 to the highest of 127. The nurses mean score was 85.59 (SD = 13.45), followed by the midwives (mean score = 82.64, SD 15.10), who ranged from 56 to 127 and 44 to 115 respectively. The lowest score was obtained by doctors and physician assistance (mean = 73.75, SD = 13.02) ranging from 38 to 108 ($P < 0.001$).

Contact or exposure of healthcare providers to people with disabilities

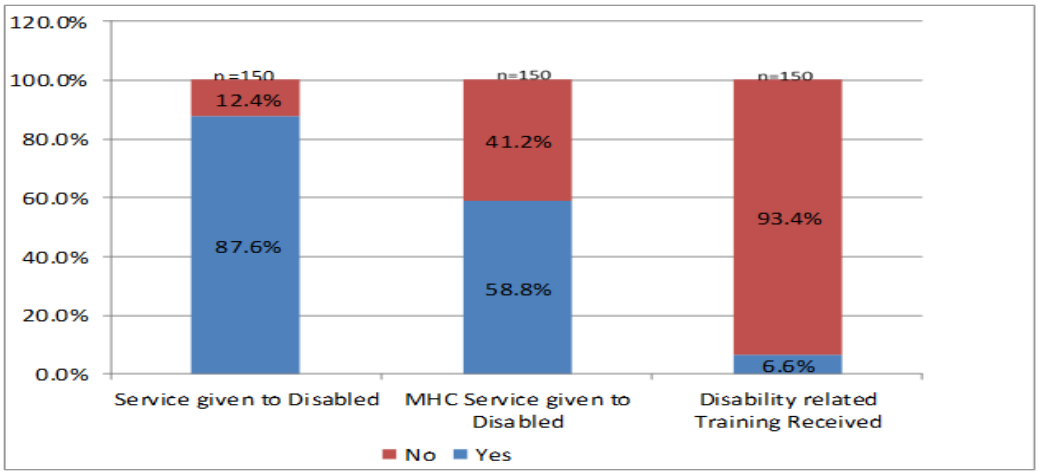

Figure 1: Contact or exposure of healthcare providers to people with disabilities

Figure 1 deals with the participants' exposure to people with disabilities. Survey participants were asked about their exposure contact to people with disabilities and any training related to disability received before or

during their service period. The majority of healthcare providers (87.6%) were found to have been exposed to people with disabilities through the provision of services, and 58.8% have given maternal healthcare services to women with disabilities. Interestingly, only 6.6% of healthcare providers have received some sort of disability-related training.

Table 3 Analysis of ATDP score by exposure variables

Exposure variables	Number	Mean	SD	P - Value
Service/Treatment given to disabled	149	88.52	14.83	
Yes	120	88.20	14.83	P = 0.252
No	29	70.78	14.12	
MHC service given to disabled women	149	88.2	14.83	
Yes	115	69.49	14.75	P = 0.052
No	34	66.35	14.79	
Disability related training received	150	68.52	14.75	
Yes	10	69.14	12.86	P = 0.852
No	139	68.40	14.87	

Table 3 reports a higher mean ATDP scores to those who gave maternal healthcare services to women with disabilities than those who did not (69.49 compared with 66.35), however, this difference was not significant P > 0.05). In addition, there was no difference in the scores between providers who received some sort of disability-related training and those who did not receive any training (69.14 vs 68.40, P > 0.05). By contrast, the mean score was lower (mean = 88.20; SD = 14.83) for those who had been exposed to persons with disabilities through the provision of general service or treatment, versus those who were not exposed (88.20 vs 70.78, P > 0.05). However, none of the exposure factors was significantly associated with ATDP score.

4.1 Disabled user's experience and perception of healthcare provider's attitude towards them Sensitivity and care

With regards to the qualitative analysis, women with disabilities reported mixed experiences and opinions about the provider's sensitivity and care. However, majority expressed bad experiences. Only few reported a positive experience with the healthcare providers, while majority did report negative encounter with healthcare providers. Some reported that the providers were caring, kind, and treated them respectfully in an enjoyable environment. Some of these people with disabilities stated that they received counselling and advice in their antennal visits and support during childbirth by the nurses and doctors at the various hospitals. One of the women in her interview reflected on her positive experience with providers by saying

> "*They treated me nicely and made me understand properly. They helped me lie down themselves…the midwives helped me in the health post, and later in the hospital, both doctor and midwives helped me*." (# participant 3)

Another participant came out with similar experience. She stated that providers were helpful and caring towards her during their antenatal visits and gave them confidence during delivery.

> "*I found health workers happy to see me whenever I went to the hospital. They used to help me, holding my hand while I entered the hospital…they always told me … 'madam walk carefully' when the floor of the hospital was damp and slippery*." (# participant 4)

On the other hand, as earlier indicated, majority of the participants reported that the providers were not welcoming and they even demean them. Some said that providers were discouraging abusive and rude. Three women with disabilities (blind) reported that they were not given complete antenatal check-ups or counselling when using services. The participants further added that the nurses frequently scolded and shouted at them during the delivery. Providers non elite area based hospitals were reported to be comparatively polite, and more sensitive and caring than providers at elite area based. While being asked about her perception of provider's skills and behaviour, a disabled participant stated:

> "*Well madam, I did not think of who is capable or skilled. All I wanted was to be treated well and polite. I got the impression that the staffs there did not give proper care. It is about a year back; I do not know if it is the same now as well*." (# participant 1)
>
> *"….. These people are sometimes abusive and inhumane. ……..*" (# participant 9)

Additionally, majority of the interview participants reported that providers did not explain things to them properly or give information about their pregnancy while attending antenatal care. It was evident that only a very few were advised to go for delivery in a health facility and none of them were informed about the need for post-natal check-ups. One of the participants reported as follows:

> *"She didn't check other things and never explained; only palpated my abdomen and sent me back with some medicines."* (# participant 10)

Another participant reported a similar experience during her first pregnancy check-up in a primary

healthcare center:

> *"When I went to the hospital they told me to do a urine test to confirm my pregnancy. They did not explain things clearly to me the first time and I returned back to home. The next time I went, the doctor asked me who had checked me before. Once I told him, the doctor was annoyed with his staff, asking why they didn't check me properly."* (# participant 7)

In addition to the problems faced by other women with disability, all of the blind service users stated that they were not guided or given proper information about where the consultation room was, and overall they found the system in the health facility frustrating:

> *"We never got the information. They only made me go from one room to the next. What would be their loss to provide help to their patients?*" (# participant 5)

Poor care, rude and impolite staff - particularly in non-elite area based hospitals were a common experience reported particularly by women with disability using the services:

> "*I found staff in the hospital rude and not at all polite.....it is for all because I have heard many people say about midwives in the hospitals that, they are very rude and treat people bad. Some of them were polite too but most of them were not like that. I might have that impression. Mostly, listening to others as well it is found that midwives and nurses are rude to those of us who have disabilities ……I do not see them (midwives and nurses) doing same to other women who are not disabled*" (# participant 8)

4.2 Maintaining distance and avoiding communication

Health practitioners often struggled to understand disabled peoples' needs as they are not formally trained to provide services to this group. Their attitudes were reported to be distant and uncommunicative by many of the women with disabilities. This discouraged them from seeking services. A number of women with disability indicated their disappointment due to the disengagement of the various providers. Additional findings from service patrons revealed that healthcare workers avoided talking to people with disabilities. This may be because as a result of how difficult it was to communicate especially with those who are dumb and deaf. It was common that the nurses and other health workers did not ask the woman directly about her problem, but rather regularly asked whoever had accompanied them. This experience left the women with disability feeling ignored. Some of the interview participants complained about attendants' poor interpersonal and communication skills that often distanced them from the service users with disabilities. One of them who has visual problem stated

> "*They (providers) used to say I was blind, and behaved as if I was deaf and could not hear them. So they asked my mum …When nobody spoke to me, I thought it was because my mum was there so they did not ask me anything but only to my mum. But after I returned home I started to feel bad; I felt they treated me like someone mentally retarded or deaf, so they asked my mum rather than asking me*". (# participant 6)

4.3 Preparedness of health workers for providing care to women with disabilities

Furthermore, the study found providers lacking in knowledge about caring for people with disabilities and also having a poor understanding of the needs and rights of people with disabilities. Most of the health workers were found to be untrained in specific skills such as communication-related to disability, which would enable them to give better and more targeted services for people with disabilities. Many people with disability also perceived that healthcare providers had no confidence in treating them. One of the service users recalled her experience concerning the clinical determination of whether she was pregnant or not:

> *"I couldn't get an idea about that at this institution here. One of the sisters was confused whether I was pregnant or not."* (# participant 2)

Another user was not confident with the provider's skills and ability to handle her delivery:

> "*I was so much afraid during the time of delivery and wondered if they could or couldn't do because I was disabled; if they would understand me or not, and if they could handle me properly or not. I was fearful of all these things….. until the final result I was afraid*" (# participant 10)

Many women with disabilities reported that the attitudes of providers and their understanding about disability were negative and often discouraging, expressing concern about sexual and reproductive health choices of women with disabilities. Some participants reported that they faced challenges due to preconceived mind-sets and limited understanding about disability and disabled people's desire and expectations. For example, one of the participants who was crippled reported that she was surprised by the doctor's advice not to have any more children due to her disability.

> *"A Doctor suggested to me not to have more than one child when I had gone for a check-up of my baby. Due to this, I aborted two pregnancies. They said this baby is healthy and not to take the risk with other pregnancies."* (# participant 4)

The information from the interview clearly suggests that the health professionals and facilities were poorly prepared and informed to give services to women with disability. Some respondents stated that they faced

problems in the government hospital because the providers were not confident about handling their delivery. One of them indicated:

> "*I was there for two days. I was about to deliver and asked them whether it is possible here or not; finally, they said we can't deliver you here and then I had to go to the university hospital."* (#participant 5)

5. Discussion

The findings of the study revealed negative thoughts towards people with disabilities among healthcare providers in the study district. The mean ATDP score for the respondents in this study was found to be significantly lower (mean score 68.5) than the normative score of 113 presented by (Akasreku, Habib & Ankomah, 2018). The literature reported the provider's ATDP scores consistently greater than 100 (Karimu, 2017).

Lack of knowledge combined with injustice against people with disabilities may perhaps have resulted in identification and negative attitudes among the providers. In Africa and beyond both prior studies showed the fact that health provider's behaviours and thoughts often indicate broader societal unfairness (Greenwood, and Wilkinson, 2013). In most cases, health providers with advanced medical skills, such as physicians, regularly emerge from the upper class level, educated backgrounds with assumptions social structure, culture and beliefs towards poor and minority (Iezzoni, 2011). Notwithstanding this, this research results established inconsistency in the relationship between the provider's attitude and some socio-demographic variables. For instance, healthcare providers working in elite areas based hospital slightly obtained higher ATDP scores; but there was no observed relationship between the place of work and provider's attitude. Match up to female providers, males had higher ATDP mean scores, signifying that males exhibit more positive attitudes towards people with disabilities. On the contrary, female nurses and auxiliary nurse midwives had higher scores than the other two categories of professional groups. Doctors, health assistants and community health nurses, both male and female, had low score. In a similar vein, female community health nurses also scored low.

Among the selected female respondents, over 70% were community health nurses may have been fairly lower than that of nurses and midwives in terms of exposure, education, and awareness about disability and disability rights. Establishing a higher percentage of respondents with low levels of education and knowledge, the lower ATDP mean score for females might have been over-weighted reflecting the attitudes of female community health nurses. This is consistent with the literature, which reports inconsistency in regards to gender difference in ATDP scores. However, the huge number of this research has been conducted in western countries. besides, a lot of the studies in the published literature were conducted in medical and nursing schools. In this body of research, women held more positive attitudes towards people with disabilities (Kpobi & Swartz, 2019). In fact, Yuker, Block, & Young, (1970) recommended the normative ATDP score to be higher for female than for male (113 compared with 110).

Additionally, number of years practicing medicine and age negatively correlated with healthcare workers' attitude scores. The study established that the healthcare providers who were more positive in their attitudes towards people with disabilities were the younger ones as compared to the older providers. This result of the study was consistent with the findings of a study conducted in South India, but argues with the findings of studies conducted in Europe and North America (Akasreku, Habib & Ankomah, 2018). The more positive attitude among younger healthcare providers perhaps indicates a generational change in how disability is viewed, with disability increasingly becoming more culturally acceptable in Asian cultures.

Furthermore, demographic variables such as gender, education, age and residence have, nevertheless, often been described as insignificant in attitudes of individuals with no disabilities towards people with disabilities (Akasreku, Habib & Ankomah, 2018). Ganle (2015) assumed that the most significant factors in attitudinal scores were exposure and the passion of the contact with people with disabilities. on the contrary, there was no observed correlation between ATDP score and exposure and knowledge variables in this study.

Another remarkable result was that the study did not find attitude differences between the providers who had received disability- related training and those who had not. This finding contradicted the study findings of Cervasio & Fatata-Hall, (2013) conducted among nurses in the United States which examined their attitude before and after disability education; and suggests that short training and exposures may not be enough to change the attitudes of Ghanaian healthcare providers towards people with disabilities.

It is also worth noting that the negative attitudes among healthcare providers found in this study may simply reflect general negative attitudes of the Ghanaian society towards people with disabilities, particularly as the majority of healthcare providers have received no training or awareness interventions to alter broader social attitudes and perceptions.

People with disability's experience and perception of healthcare provider's attitude towards them The study revealed mixed findings in regards to user's perception of providers' attitudes towards women with disabilities. Some of the participants with disabilities in their interview expressed overall positive experiences with healthcare providers, while others did not. The range of positive attitudes and behaviours displayed towards

women with disabilities have been identified in many studies, ranging from being open, friendly, and welcoming to respectful and caring. The most common negative attitudes informed by the literature in relation to healthcare workers were that healthcare workers were disrespectful, rude, discriminatory, abusive and neglectful (Ganle, 2015). A systematic review found a range of interrelated reasons for these attitudes, with socio-cultural, organizational and individual factors contributing to the attitudes and behaviours of healthcare workers (Ganle 2015).

The literature reports that disrespect, abuse and rudeness is widespread to both women with and without disabilities during facility-based childbirth (Karimu, 2017). While many women with disabilities interviewed were aware that all women both with and without disabilities might be treated poorly, many felt that their disability compounded or intensified this abuse. Moreover, facing disrespect, abuse and rudeness in many areas of their lives these women with disabilities may more hesitant than their peers without disabilities to tackle yet another series of barriers when pregnant and this may be an additional factor in when and where they decide to access healthcare services.

Interestingly, this study also found that negative attitudes and abusive behaviour predominantly among public healthcare providers in higher-level health facilities, rather than among the staff in private health facilities or community-based birthing centers. Amongst the possible explanations for this could be that there is less community involvement in the higher-level healthcare facilities in management and service delivery.

Provider's negative attitude and abusive behaviors predominating in public health facilities rather than private health facilities were consistent with the findings of Mannava et al. (2015). A recent qualitative study conducted by (Karimu, 2017) in Nepal among women with disabilities had similar findings in relation to user's perception towards healthcare provider's attitudes. However, their study revealed that provider's negative attitude and abusive behaviours differed according to types of disability, and were experienced more by women with hearing and speech disabilities.

The literature also suggests that similarities exist among healthcare provider's negative attitude and behaviours in both low and high-income countries. Consistent findings, for example insensitive, abusive health providers with the lack of knowledge, skills and limited information about the needs of people with disabilities were also reported in studies conducted in the US and UK (Mprah, Anafi and Sekyere 2014).

A broader issue may be that in resource-poor countries, the lack of respectful care from healthcare providers may have due to their dissatisfaction with the healthcare system. The literature suggests that negative attitudes and behaviours of healthcare workers are frequently related to their poor working conditions, which include long working hours, heavy workloads, , low pay, shortage of equipment and medicines (Ganle 2015). Moreover, maternal healthcare providers are often predominantly female, with relatively low status in health system hierarchy and poor salaries. Many of them may have been inadequately trained and supervised at work, and have limited autonomy yet have great responsibilities. Maternal healthcare providers in Ghana are not excluded from this situation and it maybe that their negative attitude and behaviours in part reflect their dissatisfaction with the Ghanaian healthcare system.

6. Conclusion

The findings from the study concluded that, the negative attitudes towards disabled women, their pregnancy and needs for proper maternal health amidst health providers employed in the study region are predominant. Although negative experiences are common, surprisingly, the attitudes towards people with disabilities are not common; neither do they constantly interpret into adverse experiences by disabled service users. These negative attitudes are caused by inadequate professional and public knowledge on disability and the needs of disabled people.

The current curricula and training courses which are designed for healthcare providers have no concerns or information related to disability. It was found that no healthcare provider located in the study region was trained to care for or to work with disabled people. However, the attendees for a sensitization and orientation sessions the NGO organized were a small number of healthcare providers. To develop access to maternal healthcare for women with disabilities, provision of sensitization and comprehensive training to providers of maternal healthcare and staff of other health facilities may be of help. In addition to the previous statement, primary care providers, nurses and doctors at all levels should be included in disability-related questions and qualifying tests for healthcare providers.

It was found in the study that there was a comparatively negative attitude and behaviours of providers of healthcare employed in the study region towards disabled people. The study results also revealed that disabled women that use higher-level health facilities commonly encountered negative attitudes and abusive behaviours related to those using community-level health facilities. Literature available provides more evidence and insights to assist explain this, however healthcare services access for women having disabilities remains an under-researched topic in Ghana and needs further study to evaluate and develop the efficiency of current interventions and services intended to address attitudinal barriers.

As stated above, conclusion can be made that lack of constant and operative training for specialists mean that attitudes and knowledge towards disability are often not different from attitudes and knowledge towards disability of the general public. Specified training meant for healthcare professionals is immediately required to ensure that healthcare professionals are conscious of appropriately addressing and working with persons with disabilities amongst their professional capacities.

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