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Formative analysis on social behavioural change

For Sightsavers' Disability Inclusive Development inclusive eye health project – Kogi State, Nigeria.

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Abbreviations

BCW	Behaviour change wheel
COM-B	Capability, Opportunity, Motivation – Behaviour
COVID-19	Coronavirus disease
CSR	Corporate social responsibility
DID	Disability-inclusive development
FGD	Focus group discussion
IEH	Inclusive eye health
KIA	Key interest area
KII	Key informant interview
LGA	Local government area
NHIS	National Health Insurance Scheme
OPD	Organisation of people with disabilities
RAAB	Rapid assessment of avoidable blindness
SBC	Social behaviour change
SES	Socio-economic status
WG	Washington Group
WGSS	Washington Group Short Set of questions
WG-Enhanced	Washington Group Enhanced Set of questions

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Executive summary

Introduction and objectives

Sightsavers is supporting the Kogi State government in implementing a Disability Inclusive Development (DID) inclusive eye health (IEH) programme funded by UK Aid. The two-year project will pilot an inclusive health approach to improve quality and equity in access to eye care services for women and men with disabilities in Kogi State, Nigeria, in line with the principles of the United Nations Convention on the Rights of Persons with Disabilities.

This participatory formative analysis is aimed at developing an appropriate social behaviour change (SBC) strategy to improve access to eye care services among people with disabilities in selected communities in Kogi State. The key areas of interest are:

1. To understand what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level.
2. Insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities.
3. Attitudes and behaviours of health facility staff towards people with disabilities and how this reflects on their health outcomes.

Findings from this study will help the project to design an appropriate SBC strategy, interventions and materials (aligned to the contexts of the primary project beneficiaries and stakeholders) that will drive the improved access to eye care services among people with disabilities in targeted communities in Kogi State.

The formative analysis began with a review of local literature targeted at the three (3) key areas of interest for this study. Literature found was included in the study based on two criteria: the research must have been conducted in Nigeria and it must contain findings on any of the three (3) key areas of interest stated above. In total, seven (7) peer-reviewed materials (published within 2007 and 2020) were used in this study.

Methodology

The formative analysis was designed as a cross-sectional descriptive study complemented by qualitative techniques. The study was underpinned by two (2) models and frameworks: the Capability, Opportunity, Motivation – Behaviour (COM-B) model was used to provide insights on the factors that enable or prevent people with disabilities from seeking health care at a hospital and/or at community level (key interest area 1); the force field framework was also deployed to gain insights into factors that promote and minimise stigma and discrimination against people with disabilities in the communities (key interest area 1). To apply both frameworks, the formative analysis was designed using mixed methods (mini surveys, focus group discussions (FGDs) and key informant interviews (KIIs)) to support a robust triangulation of insights.

The study was conducted in two of the 21 local government areas (LGAs) of Kogi State, north-central region of Nigeria – Ankpa and Kabba-Bunu LGAs. Sightsavers works with the zonal hospitals as key partners in Ankpa and Kabba to provide health care services for people living with disabilities in the region under the DID IEH project.

In terms of design, the study adopted a purposive sampling method to select respondents for each of the three key areas of interest. For key interest 1, the team worked with members of organisations of people with disabilities (OPDs) in Kogi State to identify and invite various categories of disabled people (visually impaired people, deaf people, and those with physical, intellectual, and mental impairments) from rural communities to participate in the study based on their availability and willingness. The disabled people also gave feedback on some of the key issues under key interest areas 2 and 3. Regarding key interest 2, OPD members also identified and congregated willing family members of people with disabilities, and key community actors for the study. For key interest 3, Sightsavers programme representatives at the zonal hospitals (Desk Officer, Hospital Management Board) identified various categories of health care workers (including doctors, nurses, laboratory staff and so on) to be interviewed.

Regarding data collection tools, a mixed-method technique utilising mini-surveys, focus group discussions (FGDs), and key informant interviews (KIIs), was used to enable adequate analysis and triangulation of data. For the first study objective focusing on people with disabilities, a COM-B screening behaviour tool was administered to respondents to understand the factors that enable or prevent them from seeking eye health services. In addition, a mini questionnaire on demographics was also administered to the respondents to understand their socio-economic background. The mini questionnaire included the Washington Group Questionnaire (WGQ) extended set to enable us to identify and categorise disabled people correctly. To address the qualitative component, an FGD question checklist was used to interview and gain further insights from the respondents on the behavioural issues and other factors that affect their ability to access health care services. For the second objective, a force field questionnaire was used to understand the stigma and social norms that shape the health-seeking pattern of people with disabilities. To address the third objective, a semi-structured questionnaire was administered to the health workers to understand their attitudes, behaviours and perception towards people with disabilities. All the data collection tools developed were reviewed and validated by the Sightsavers team before being used for the study.

Data collection itself was designed using electronic channels to improve the overall quality of data used for this analysis. All quantitative tools developed were programmed into **KoBoToolbox** to facilitate electronic data collection. The KIIs and FGD sessions were documented using digital recording devices. All the respondents were interviewed in the zonal hospital premises in both Ankpa and Kabba LGA. Four (one female, three males) trained enumerators administered the study tools, and sign language interpreters were recruited and trained to assist in interviewing hearing impaired respondents. Since all interviews were conducted face-to-face with the respondents, COVID-19 safety measures were adhered to (including social

distancing of one metre and use of face masks and hand sanitisers) to ensure the safety of respondents and data collectors.

Key study findings

One hundred and eighteen (118) (42.5% female) people were interviewed comprising of 40 people with disabilities (42.5% female), 25 family members (56% female), 21 community stakeholders (47.6% female) and 32 health workers (53.1% female). Insights from the study are summarised below by key interest area:

Key interest area 1 – Factors that enable or prevent people with disabilities from seeking eye health care

Five (5) factors were determined by the study as the most important motivators that enable or encourage people with disabilities to seek eye health care; these are summarised below.

1. Awareness of the importance of the eye and the desire to regain or maintain good eyesight was mentioned by all categories of people with disabilities as a critical factor. This awareness has been reinforced by their knowledge of people who have become blind and gone through hard times as a result. Also, the desire to avoid stigmatisation and discrimination resulting from a loss of eyesight. Deaf people and physically impaired people are additionally conscious that they are already disabled and hence must do all they can to maintain their eyesight and avoid the perceived burden of multiple disabilities.

2. Availability and knowledge of equipped and functional health care facilities also emerged as an important factor. The presence of qualified specialists, including sign language interpreters for deaf people, was highlighted as a key driver. The importance of ease of movement and access within the different sections of the hospital was also highlighted as an enabling factor by physically impaired people. A well-equipped hospital pharmacy where participants could purchase most of the prescribed medications instead of trying to source the drugs in another location was mentioned repeatedly by many respondents.

3. Another key category of enabling factors is the support, encouragement, enlightenment and ready assistance from family and community, including health care workers, religious bodies, NGOs and institutions. This factor was expressed strongly by visually impaired and physically impaired people. Where family and community members are supportive and express genuine love and care rather than show discriminatory attitudes, those with disabilities feel encouraged and willing to go for eye health checks. Similarly, counselling, encouragement and positive attitudes from health care workers further inspire people with disabilities to attend their follow-up hospital appointments. Free and subsidised medical treatment by churches and NGOs is another driver under this factor.

4. Availability of financial resources or funds was determined to be a crucial enabler for all categories of disabled people. Funds are needed to facilitate

transport to the hospital for an initial check-ups and subsequent visits, payments for hospital registration cards and consultation fees, and the purchase of prescribed medication.

5. Lastly, physically impaired people mentioned that the manifestation of symptoms of severe eye defects often results in an automatic decision to visit the eye health care centres or hospitals for checks.

Six (6) factors were determined as the most prominent factors that prevent or limit the decision of people with disabilities from seeking eye health care.

1. Top on the list of barriers for all categories of people with disabilities is poverty. Due to their disability, many of those interviewed rely on handouts and cash transfers from family members and friends to survive. Most are also unemployed and are unable to sustain their livelihoods as a consequence. The limited funds in their possession are barely enough to cater for their basic needs and are often allocated to the purchase of food and daily sustenance items rather than to health care checks.

2. For visually impaired people, loss of hope and belief that there is no cure or remedy for their eye condition is a primary demotivator to seeking eye health care. This state of mind is often fuelled by discouragement from family and friends who continually ridicule any attempt they make to seek eye health care as an effort in futility.

3. Fear of being stigmatised and discriminated against by people they meet on their trip to, and within, the hospital is another factor identified by visually and physically impaired people as a key challenge and demotivator.

4. All categories of people with disabilities interviewed expressed displeasure with the poor attitude of some health care workers they have met. For deaf people, the experience is compounded by communication problems, especially where there are no sign language interpreters.

5. Inadequacies at the health care centres also emerged as a major barrier for all categories of people with disabilities. These shortfalls include inadequate experts and specialists where student health care personnel are often assigned to attend to them. Also, unavailability or limited availability of sign language interpreters to assist deaf people to communicate with health care workers, inadequate mobility aids to facilitate movement within the health care facilities, and limited availability of prescribed medications in the hospital pharmacies.

6. Finally, ignorance on the need for regular eye checks was highlighted as a major barrier by many respondents across all categories of people with disabilities interviewed. Many only summon the courage to visit the eye health centres when they have severe symptoms of eye defects.

Key interest area 2 – Stigma and social norms that define the eye health-seeking pattern of people with disabilities

The study revealed the incidence and influence of stigma and social norms on the eye health-seeking behaviour of people with disabilities. Regarding the primary origins and sources of stigma, it was established that much of this stems from the longstanding practices of native doctors and the entrenched belief that disability is a punishment from the 'gods'. This punishment is seen to be either due to the sin of the person with disabilities (where the disability came after birth) or the sin of parents or relatives of people with disabilities (where the disability is congenital). Similarly, spiritualists and some religious leaders have advanced the belief that disabled people are cursed, capable of harm and should be avoided. Since their followers trust them implicitly, this further fuels the stigmatisation and discrimination of people with disabilities. Away from these traditional and spiritual connotations, people with disabilities are also stigmatised due to the difficulty people may have communicating with them (for instance, deaf people); the belief that their conditions are communicable; their social outlook and appearance (their pattern and type of dressing); and their living standards and poverty status.

Following the interactions with family members of people with disabilities and community actors, the force driving the acceptance and support for people with disabilities in households and communities is humanity. This includes individuals' inherent compassion, and love; religion and faith; wealth status of people with disabilities; education, talent, skills exhibited by people with disabilities; personal experience of having family members with disabilities and societal level of education and knowledge.

Likewise, the forces restraining the acceptance and support for people with disabilities in households and communities are based on individual perceptions and circumstance. Towards people with disabilities, this can include judgement based on their socio-economic status (SES), challenges they have communicating, personal traits and appearance and the perceived temperament of people with disabilities. Other factors may include government failures; individual cultural and traditional beliefs; deliberate alienation of some people with disabilities; genuine ignorance of causes of disability and spiritual and religious beliefs.

To achieve the desired change – total acceptance and support for people with disabilities in households and communities – interventions to amplify the positive influence of the driving forces and limit the effect and influence of the restraining forces need to be designed and implemented sustainably.

Key interest area 3 – Attitude of health care workers towards people with disabilities

Results from the study showed that many of the health workers have a positive perception of people with disabilities. Both trained and untrained health care workers provided correct responses to almost all the behavioural questions posed to them.

Most of the health workers disagreed with the following belief statements: 'health of people with disabilities is not as important as the health of people without disabilities.' 'Cost of the care of people with disabilities is too high for any government or interested persons/institutions to cope with.' 'Reproduction must be

discouraged among people with disabilities to reduce their population.' 'People with disabilities should be used for drug trial testing and other medical research.' 'Separate hospitals should be established for people with disabilities to remove public nuisance.' 'People with disabilities should be restricted from public gathering/places to reduce distractions.'

Conversely, most of the health workers agreed that health workers should be specially trained to meet the needs of people with disabilities, and that separate hospitals should be established for people with disabilities because they deserve good care. It must be noted, however, that while people with disabilities may require specific services (such as rehabilitation and psychosocial support) provided in specialist facilities, they also deserve equitable access to health care as is provided for everyone in other health care facilities. One question where a different response was obtained was on 'whether separate hospitals should be established for people with disabilities to remove public nuisance', where those trained disagreed and those untrained were undecided.

During the FGDs, many of the people with disabilities mentioned the attitude of health care workers as one of the major factors that prevented them from seeking eye health checks. This view is supported by an instance where a health care worker narrated a 'bad behaviour' from a person with a disability while oblivious of her own action which triggered the reaction.

Certain challenges were expressed by the health workers which shape their interaction with people with disabilities in the hospitals. First, they mentioned that they have not received enough training on how to specially care for people with disabilities. Some of them were only introduced to courses on working with people with disabilities during their nursing training; some attended training organised by Sightsavers, while others have never been trained. The next challenge mentioned focused on communication with people with disabilities; the health workers stated that they had serious problems communicating with deaf people, unlike visually impaired or physically impaired people since they didn't understand or use sign language. They mentioned that many of the deaf people themselves also do not know sign language. In many service points in the hospitals, sign language interpreters are not available to aid in communication with people with disabilities. Thirdly, the health care workers highlighted their inability to devote more time to people with disabilities due to the high number of patients waiting to be attended to at any given point in time.

Proposed interventions

To address the barriers summarised for each key interest area and based on the views and interactions of the respondents, this study proposed intervention types and specific activities aimed at contributing to the expected behavioural outcomes. This includes increased visitation to hospitals by people with disabilities for eye health care, total acceptance of people with disabilities within families and communities, and improved attitude of health care workers towards people with disabilities.

To achieve the targeted behavioural outcome of key interest area 1 – increased visitation to hospitals by people with disabilities for eye health care purposes, the following intervention activities were suggested to address specific key barriers:

a. To address the financial barrier faced by people with disabilities, environmental restructuring and enablement interventions were proposed. These include: the pursuit of funding to introduce subsidies and organise free medical outreaches; encouraging individual and private corporate social responsibility (CSR) contributions; encouraging people with disabilities to sign up to the National Health Insurance Scheme (NHIS) and advocating for the inclusion of more eye drugs covered in the NHIS with special considerations for people with disabilities; and, finally, to advocate to the government to allocate more funds to eye health care for people with disabilities.

b. To restore the hope and belief of people with disabilities, the following educational and persuasion-based interventions were suggested: hold enlightenment events focusing on restoring hope and the benefits of caring for the eye; also, to design and disseminate appropriate communication materials in this regard and identify and share relevant testimonials and success stories.

c. Regarding the inadequacies in health care centres (inadequate expertise, sign language interpreters, accessible facilities, medications and so on), the following environmental restructuring and enablement interventions were proposed: the engagement of hospital management to put mobility enhancement aids in place for people with disabilities and increase specialist staff available, including sign language translators; advocating for improved supply of eye medications at various hospitals; and encouragement of individual and private sector CSR contributions.

d. To improve awareness around the importance of regular eye-checks by people with disabilities, some educational and persuasion-related intervention actions were proposed. These include: holding awareness creation sessions on the dangers of late detection of eye defects and engaging traditional and religious leaders to sensitise their subjects on the need to go for these regular checks. Other suggested intervention activities include: the provision of incentives at screening centres (incentivisation); design of flyers using pictures to show the effect of late detection of eye diseases (coercion); identifying and sharing testimonials and success stories on early detection (modelling); and facilitating free or subsidised eye health care outreaches (environmental restructuring and enablement).

Similarly, to achieve the targeted behavioural outcome of key interest area 2 – total acceptance of people with disabilities within families and communities, the following intervention types and activities were suggested to address the issues around stigmatisation and discrimination:

a. Two (2) educational and persuasion activities suggested include: holding targeted awareness creation sessions for families, communities, and public and private sector institutions on the causes of disability and the dangers of

stigmatisation and discrimination; plus, engaging community, traditional and religious leaders to sensitise their subjects and lead the campaign against stigmatisation and discrimination.

b. Several capacity-building activities were suggested to empower people with disabilities, including training on appropriate vocational skills to help them secure fulfilling employment opportunities; training family members of people with disabilities on how to care and support them; and training of people with disabilities on life skills to build their confidence, self-worth, inter-personal and communication skills.

c. To deter those who continually discriminate against people with disabilities, restrictive intervention actions proposed include: engaging the government to implement the rights of disabled people as enshrined in the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018. Also, engaging traditional and community leaders to sanction those who discriminate against people with disabilities.

d. Environmental restructuring and enablement intervention activities proposed include: facilitating the enrolment of people with disabilities into special schools; facilitating the creation of employment opportunities and linking these to people with disabilities so they can secure jobs. Also, advocating to the private sector to employ qualified people with disabilities and advocating to government and the private sector to allocate more funds to special schools for people with disabilities. Finally, engaging more NGOs (especially those working at the community level), including the OPDs, to continue to champion the rights of people with disabilities.

e. To counter the notion that people with disabilities are not useful to the community, the study proposed a modelling intervention activity – identification and sharing of relevant success stories on people with disabilities who are excelling and contributing to society.

Finally, to achieve the targeted behavioural outcome of key interest area 3 – improved attitude of health care workers towards people with disabilities, the following were suggested.

a. Hold interactive sessions with health care workers to understand their limitations, the challenges they face and how to overcome these and be more supportive. This educational and persuasion-related intervention offers the opportunity to provide feedback from people with disabilities, understand the health worker's perspective, and stimulate increased adoption of the proposed behaviour.

b. Core capacity-building interventions suggested for health care workers include training on care for people with disabilities, along with training on ethics and soft skills, including negotiation and communication.

c. Other intervention activities suggested include establishing a periodic award to reward compliant health care workers (incentivisation); putting in place

feedback boxes at various service points; and enforcing hospital rules on patient care and management (restriction).

In conclusion, the researcher invites the Sightsavers team to review these recommended actions and determine those that can be utilised in the development of an appropriate SBC strategy. It will also be useful to look at how they may be used in other advocacy work and initiatives aimed at improving access to eye care services among people with disabilities in selected communities in Kogi State.

1. Introduction

1.1. The Disability Inclusive Development (DID) inclusive eye health (IEH) project

Sightsavers is supporting the Kogi State government in implementing a DID programme funded by UK Aid. The two-year project will pilot an inclusive health approach to improve quality and equity in access to eye care services for women and men with disabilities in Kogi State, Nigeria, in line with the principles of the United Nations Convention on the Rights of Persons with Disabilities. [6]

Simultaneously, the Kogi State government was supported in implementing a comprehensive eye care programme that aimed to strengthen the local eye health system and improve access to eye care in the State, with scale-up options on eye health across the country and inclusive health care in Kogi State. The project is currently being executed in Kogi State in two eye health centres in Kabba and Ankpa LGAs and two outreach centres – Okene and Idah LGAs. [6]

The IEH project will adopt an SBC methodology to identify key stakeholders and influencers in the eye health sector and within communities, to carry out specific behavioural change interventions. The SBC strategy seeks to raise awareness of eye health conditions and available services while addressing stigma and discrimination related to disability at the community level. [6] Specific strategies will be developed using a participatory approach with stakeholders from a variety of backgrounds, including people with disabilities, self-help groups, civil society organisations, community members, health care staff and community leaders. The strategy itself will refine the behaviours (or practices) we want to influence, determine who needs to make these changes, review what we know about the behaviours, prioritise what we want to change and decide on the most effective interventions and techniques to influence them. [6]

A Rapid Assessment of Avoidable Blindness (RAAB) was designed to measure the magnitude and causes of visual impairment and the extent to which services are reaching different groups of people, and was conducted in Kogi State in 2019 by Sightsavers. [18] Findings showed that the prevalence of moderate visual impairment was almost twice as high among the poorest 20 per cent of families, compared to the richest 20 per cent (9.5% vs 5.5%, respectively). [18] Also, the study revealed that the prevalence of severe visual impairment or worse, with the best available correction, was more than 27 times higher among people living with additional, non-visual disabilities than people with no disability. Men with additional, non-visual disabilities were also significantly more likely to be blind or visually impaired, compared with female counterparts. [17]

1.2. Purpose of the formative analysis

This participatory formative analysis is aimed at developing an appropriate SBC strategy to improve access to eye care services among people with disabilities in selected communities in Kogi State. [6]

The key areas of interest are:

1. To understand what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level
2. Key insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities
3. Attitudes and behaviours of health facility staff towards people with disabilities and how this reflects on their health outcomes

Findings from this study will help the project to design an appropriate SBC strategy, interventions and materials (aligned to the contexts of the primary project beneficiaries and stakeholders) that will drive the improved access to eye care services among people with disabilities in targeted communities in Kogi State.

1. Literature review

2.1 Theoretical frameworks

2.1.1 The Capability, Opportunity, Motivation – Behaviour model

The Capability, Opportunity, Motivation – Behaviour (COM-B) model was used as the framework for analysing the first key study interest area – understanding what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level.

The COM-B model is a theory that facilitates the understanding of barriers and enablers of behaviour change. Developed by Michie et al, [5] the model guides the understanding of any behaviour of interest and facilitates the identification of behaviour targets which can become the basis for intervention design. The model proposes that for a person to engage in any behaviour (B), the individual needs to be physically and psychologically capable (C) of using social and physical opportunities (O) via motivators (M) that are reflective or automatic. [4]

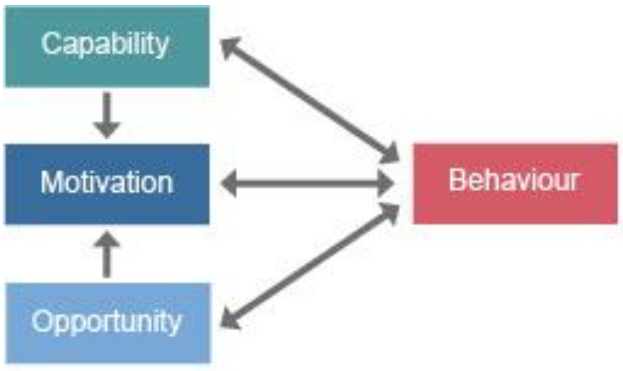

Figure 1: The COM-B model framework [5]

Figure 1: In this 'behaviour system', capability, opportunity and motivation interact to generate behaviour that, in turn, influence these components.

- Capability is defined as the individual's psychological and physical capacity to engage in the activity concerned. It includes having the necessary knowledge and skills. [5]
- Opportunity is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it. [5]
- Motivation is defined as all the brain processes that energise and direct behaviour, not just goals and conscious decision-making. It includes habitual processes, emotional responding, as well as analytical decision-making. [5]
- The single-headed and double-headed arrows represent potential influence between components in the system. For example, opportunity can influence

motivation as can capability; enacting a behaviour can alter capability, motivation and opportunity. [5]

While this is a model of behaviour change, it also provides a basis for designing interventions aimed at behaviour change. Applying this to intervention design, the task would be to consider what the behavioural target will be, and what components of the behaviour system will need to change to achieve it. [5]

The benefit of employing the COM-B model over a single theory of behaviour is that several distinct and explanatory components connecting the individual and the immediate social environment are outlined. COM-B lies at the centre of the behaviour change wheel (BCW), a toolkit for designing behaviour change interventions, [1] and is the starting point of intervention development.

COM-B components can be mapped onto the BCW and the behaviour change technique taxonomy which facilitates the selection of intervention strategies that are likely to be appropriate and effective in addressing the barriers and enablers for each component. [1]

The COM-B model has been successfully applied to investigate various health behaviours and shape interventions. For example, it was used to study barriers and facilitators to chlamydia testing in general practice for young people and primary care practitioners, [1] to investigate barriers and enablers to delivery of the Healthy Kids Check, [2] to study medication adherence, [3] and to develop an intervention to improve hearing-aid use in adult auditory rehabilitation. [4] In this formative analysis, the COM-B model was applied to provide insights on what enables or prevents people with disabilities from seeking health care at a hospital and/or at the community level.

2.1.2 The force field framework

The force field framework was used to understand the stigma and social norms that define the health-seeking pattern of people with disabilities. Originated by Kurt Lewin in the 1940s, the force field analysis is widely used by social scientists and other researchers to analyse barriers to change.

The idea behind force field analysis is that stability is dynamic, not static, and that situations are maintained by an equilibrium between forces that drive or enable change and those that restrain or resist change. [20] For change to happen, the driving forces must be strengthened, and the resisting forces weakened, [20] see Figure 2.

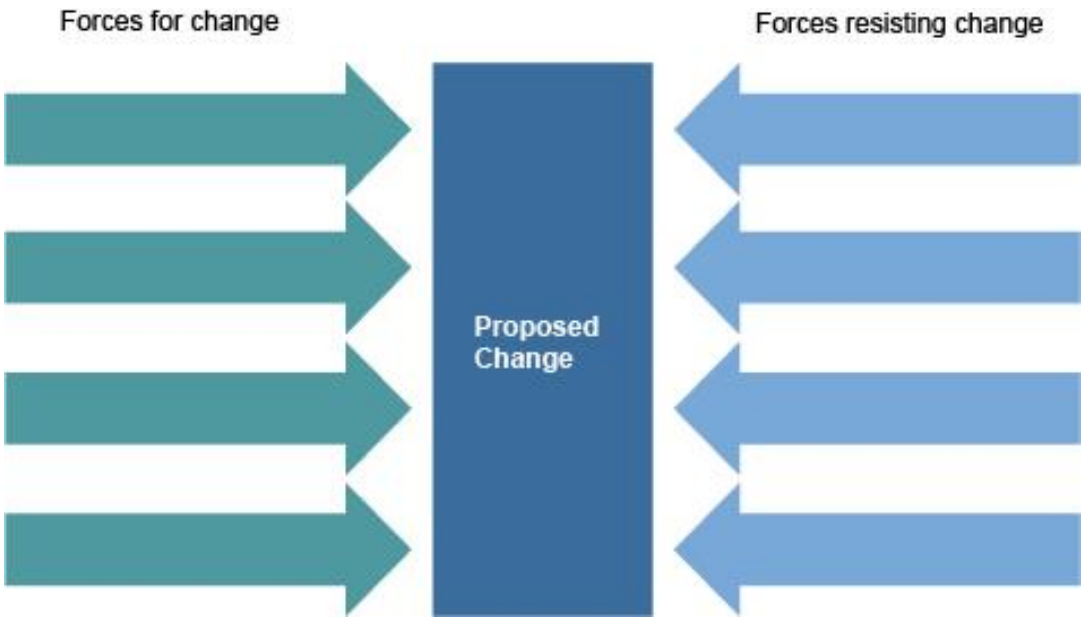

Figure 2: Force field framework [21]

Application of the force field methodology typically involves five (5) steps. These are: describing the proposal for change (for this study: inclusion of persons with disabilities in eye health); identifying forces for or in support for the proposed change; identifying forces against the proposed change; assigning forces – scoring each force from 1 (weak) to 5 (strong) according to the degree of influence each one has on the proposed change and adding up the scores for both sides and, finally, analysis and application. [19]

Force field analysis has been deployed by various researchers in numerous disability and health-related studies, including balancing overuse and underuse in the Iranian health care system, [19] reflecting on the methodological aspects of a critical ethnographic approach used to inform change for adolescents with disabilities, [22] factors in the employment of developmentally disabled persons, [23] and analysis of forces influencing innovative roles in primary health care nursing. [24]

2.2 Review of relevant literature

The study began with a desk review of local literature targeted at the three (3) key areas of interest for this study. These included: (a) factors that enable or prevent people with disabilities from seeking health care at a hospital and/or at the community level, (b) stigma and social norms that define the health-seeking pattern of people with disabilities, and (c) attitudes and behaviours of health facility staff towards people with disabilities reflecting on their health outcomes.

The search for relevant literature was actioned primarily using ResearchGate, a professional network for scientists and researchers used by over 20 million people from all over the world to share, discover and discuss research. The repository contains a wide range of published materials, from various peer-reviewed journals and libraries, including Open Journal of Ophthalmology, PubMed, Global Health

Action, Medline, SAGE Journals, Springer and so on. The reference list on each downloaded material was reviewed further and relevant materials therein were searched for as well. The literature found was included in the study based on its fulfilment of two criteria: the research must be conducted in Nigeria and must contain findings on any of the three (3) key areas of interest stated above. In total, seven (7) peer-reviewed materials (published within 2007 and 2020) were used in this study (see **Annexe 1**).

One study conducted in 2018 aimed to determine the level of disability (percentage of the sample with disability), accessibility and utilisation of rehabilitation services in Kano State. Findings show that the majority (63.6%) of the participants didn't know about the support centres (that provide a range of support for all people with disabilities, including psychosocial support) in their community. 19.3% of the respondents visited these support centres in the community, while 78.4% did not utilise the service. The authors believe that this could be due to the expensive nature of the services and the distance between the communities and the rehabilitation centres. [8]

In 2011, a study entitled 'The Face of Disability in Nigeria: A Disability Survey in Kogi and Niger States' was conducted. Among other areas, the authors enquired about the use of health care services by disabled persons (37% with visual impairment, 30% with physical impairment, 15% deaf persons, 9% with mental or learning impairment). They found that the most common services accessed were general health (90%), traditional healers (60%), counselling (57%) and basic amenities and infrastructure (such as water, electricity, roads) which facilitate better access to health (50%). Respondents in Kogi State accessed and used health services and basic amenities between three and ten times more than those in Niger State. The least-used health services included medical rehabilitation (30%), assistive devices (24%), welfare services (22%), special education (15%), vocational training (10%) and economic empowerment (4%). For all services (except for basic amenities), the percentage of women using services was lower than men. Going further, the researchers enquired about the reasons for the non-use of health care services. The most common reasons given for not using services apart from traditional healers, were ignorance about the service or its high cost. Of the 352 of respondents with mobility disabilities, 73 pieces of motility equipment were reported: 38 crutches, 11 walking frames, 10 wheelchairs, 8 special pairs of shoes, 3 callipers, 2 artificial limbs and 1 tricycle. The three most common areas that facilitated community participation among respondents were their acceptance and integration (22%), government assistance (13%) and assistive devices (12%). The three most common factors that make participation in the community harder were no support for integration (19%), lack of government assistance (18%) and having a disability (16%). [9]

In 2017, a study examining the attitude of health personnel in Calabar and factors affecting health care service uptake for persons with physical impairment in Nigeria was conducted. Findings showed that 56.33% of the health workers have a negative attitude towards people with disabilities. Most of the respondents (86.04%) held the view that access to health care facilities is very difficult for most people with disabilities in Nigeria. 69% of the respondents were of the view that friends and

family members do not take people with disabilities to hospital on time. The fact that many of the health workers were not exposed to how they can take care of people with disabilities was confirmed by 69.8% of the study respondents. 61.89% of the respondents also pointed out that there is a dearth of health/medical literature on the health of people with physical impairments in Nigeria. [10]

A study (written using secondary data) published in 2017 examined the problems of living with disability in Nigeria, with the aim of understanding the negative experiences faced by those living with a disability. The author found the poor attitude of individuals and society towards those with disabilities was often perpetuated by traditional beliefs that disability can be attributed to punishment from the gods for actions in present or past incarnations. People with disabilities also faced negative attitudes from some health workers and also struggled with regard to paying medical bills, accessing health care services at established teaching, orthopaedic and other specialist hospitals, and access to health care services provided by the National Health Insurance Scheme. The author also highlighted some environmental obstacles, including access to transportation and access to both public and private buildings. According to the study, there was no wheelchair access for street crossings or adequate facilities to aid access into public buildings, and affordable and practical mobility aids are still rare. If a person is physically disabled, he or she generally does not leave home. [11] The author also highlighted that disabled people experience and suffer from the discriminatory attitude of most members of the public and the government in terms of policy, decision-making and implementation on issues that affect their lives. In Anambra State, approximately 5,000 disabled people protested because of their bitter experience of neglect and humiliation by the government on ‘World Disable Day’. The study further highlighted the issue of lack of participation by people with disabilities in mainstream decision-making in Nigeria. This is attributed to the fact that 90% of people in Nigeria view the disabled populace as the target of aid, charity and humanitarian assistance rather than active citizens in society and national development. Most of the time they are excluded from participating in decision-making as a consequence [11].

Another study was conducted in 2019 on the determinants of health care-seeking behaviour and unmet need among people with physical disabilities in Nigeria. For health care-seeking behaviour, results from both univariate and multiple regression analysis show that gender, age, location, SES, health status, and perceived cost of health care were significantly associated with health care-seeking behaviour. The study found that females, over 50s and urban dwellers were more likely to seek health care versus their respective counterparts. High SES was also significantly positively associated with frequent health care-seeking compared to poor SES. Self-reported health status as a proxy for health care need was found to be significantly associated with health care-seeking; those who rated their health as good regularly utilised more health care services compared to those who rated their health poorly. Among access factors, only the perceived cost of services continued to be significantly associated with health care-seeking. Respondents who stated that costs associated with health care-seeking were expensive utilised health care significantly less than those who considered the cost to be cheap. [12]

Regarding unmet health care needs (controlling for health care-seeking behaviour), results from the same analyses showed that gender, age, location, SES, income, health status, distance and perceived service quality influenced the reporting of unmet need for health care. Female respondents and those over 50 years old were more likely to report unmet health care needs. Living in urban areas had significantly reduced the odds of experiencing unmet health care needs compared to those living in a rural setting. In contrast, those from a higher SES had significantly lower odds of reporting unmet health care needs compared to those from poor households. Similarly, those from households with a total income of less than ₦15,000 had significantly higher odds of reporting unmet health care needs. Results also show that those who rated their health as good were significantly less likely to report unmet health care than those with poor health. Travelling more than 4km for health care significantly reduced the odds of reporting unmet health care needs. Perceived quality of care continues to be associated with unmet health care needs as respondents that rated health care as good were less likely to report unmet needs. [12]

A qualitative study was conducted in 2016 to understand the barriers to accessing services by people with disabilities in Nigeria. Insights showed that structural and physical barriers to accessing programmes and services adversely affected all aspects of the lives of people with disabilities in the country. Places of business, health care, education, employment, transport, recreation, sport and leisure and within the justice system had major structural barriers which prevented people with disabilities from accessing programmes and services they provided. All participants who used mobility aids (including guide canes or wheelchairs) reported physical barriers (such as narrow security cages in banks used for metal detection) that restricted their access to programmes and services. They lamented that buildings in Nigeria were not “disability-friendly”. Accessibility was not just a problem for those using wheelchairs or walking aids, but also for people with visual impairments. A blind participant stated: “Considering the kind of environment we live in with physical obstacles everywhere, mobility is one area that blind people have a problem in attempting to access programs and services”. [13]

In 2020, a study was conducted on the accessibility for people with disabilities to productive resources in Nigeria. Results also show that the majority (92.1%) of people with disabilities in Nigeria had inadequate access to primary health delivery. Reasons for this may include the poor SES of many persons with disabilities and that many live in rural areas where medical and other services are scarce, or not available. The study also determined that the attitude of some health workers towards disabled persons who did manage to access health centres were sometimes negative. [14]

Finally, findings from the literature review were analysed and mapped against the COM-B model; aspects of the model where significant knowledge gaps exist were determined and prioritised for in-depth study in the formative analysis.

2.2.1 Mapping of COM-B model with literature review findings

Findings from the literature review were mapped into the COM-B model (see Table 1) to (1) identify the barriers and enablers in terms of Capability (physical and psychological), Opportunity (physical and social), and Motivation (reflective and automatic) of people with disabilities from seeking health care at a hospital and/or at the community level, and (2) determine gaps for further inquiry during the formative analysis.

Table 1: Mapping of literature review findings on eye care-seeking behaviours into the COM-B model

COM-B model components	Sub-components	Barriers/enablers to health care-seeking behaviours by people with disabilities
Capability: Individual's psychological and physical capacity to engage in the activity concerned [5]	Physical capability Capacity to engage in the necessary physical processes et al. [5]	• Mobility [13]
	Psychological or mental capability – Capacity to engage in the necessary thought-comprehension, reasoning [5]	• Ignorance about available health care service [9]
Opportunity: Factors that lie outside the individual that make the behaviour possible or prompt it [5]	Physical opportunity the opportunity afforded by the environment [5]	• Distance to the health centre [8], [12] • Availability of health care centres [14] • Structural limitations of facilities (the lack of ramps, lack of lifts, narrow entrances and corridors, inaccessible restrooms, and tight, over-crowded offices) [13] • Residence location (urban/rural) [12], [14]
	Social opportunity afforded by the cultural norms that dictate the way that we think about things (such as the words and concepts that make up our language) [5]	• Attitude of health care workers [10], [11] [14] • Social exclusion, stigma and discrimination enforced by traditional beliefs) [11]

Motivation: Brain processes that energise and direct behaviour [5]	Automatic motivation Emotions and impulses arising from associative learning and/or innate dispositions [5]	
	Reflective motivation Involving evaluation and plans [5]	• Cost [8], [9], [11], [12], [14] • Perceived health status (good or bad) [12] • Perceived quality of services [12]
Other factors		• Gender [12] • Age [12] • Education [12] • Socio-economic status [12] • Policy and rights [11]

2.2.2 Priority areas for the formative analysis

There are limited published materials on access to health care services among people with disabilities in Nigeria. Also, none of the studies found used the COM-B model to explore the behavioural issues on eye health care-seeking behaviour of people with disabilities. Similarly, none of the studies reviewed used the force field analysis method to investigate issues around stigma and discrimination.

The findings from the literature review did not sufficiently address the three objectives of the study. Looking at Table 1 above, while some of the barriers and enablers to health care-seeking behaviours by people with disabilities were identified and mapped to some components of the COM-B model, little insight on stigma and social norms that shape the health-seeking pattern of people with disabilities were found.

The study was designed to elicit information to comprehensively address the three objectives of the study. Information from the literature review was used to extend the scope of the qualitative tools; this is to ensure that findings are comprehensive and responsive to each of the three key study areas of interest.

2. Methodology

3.1 Research design

The formative analysis was designed as a cross-sectional descriptive study. As stated, the COM-B model was used to provide insights on the factors that enable or prevent people with disabilities from seeking health care at a hospital and/or at the community level. The force field framework was also deployed to gain insights into factors that promote and minimise stigma and discrimination against people with disabilities in the communities. In applying both frameworks, the formative analysis was designed using mixed methods (mini-surveys, FGDs and KIIs) to support a robust triangulation of insights.

3.2 Study area

The study was conducted in two of the 21 LGAs of Kogi State, north-central region of Nigeria – Ankpa and Kabba-Bunu LGAs.

Ankpa LGA, located in Kogi East Senatorial District, has a land size of 1220.258km^2 and a population of 266,176 people – 132,471 females, 133,705 males (as at the 2006 census). [15] Ankpa LGA shares boundaries with Omala LGA (north), Dekina and Ofu LGAs (west), Olamabolo LGA (south), and Apa and Otukpo LGAs of Benue State (east). Ankpa LGA headquarters is at Ankpa and is located between latitude 7° 22'14" N and Longitude 7° 37'31" E. [18] The major ethnic group in the LGA is Igala, although there are other ethnic groups like Idoma and Igbo. [18]

Kabba-Bunu LGA, located in Kogi West Senatorial District, has a land size of 2757.57km^2 and a population of 144,579 people – 72,639 females, 71,940 males (as at the 2006 census). [15] Kabba-Bunu LGA lies between Latitude: 7° 49' 25.79" N and Longitude: 6° 04' 13.80" E [16], and shares boundaries with Ijumu, Lokoja, Yagba East, Okehi and Mopa-Muro LGAs. The headquarters of the LGA is in Kabba town which lies between Latitude: 7° 49' 37.88" N and Longitude: 6° 04' 30.07" E. Kabba is located near the Osse River, at the intersection of roads from Lokoja, Okene, Ogidi, Ado-Ekiti, and Egbe. [17] The language spoken by the inhabitants is Yoruba, while the dialect is Okun.

Sightsavers partners with the zonal hospitals in Ankpa and Kabba to provide health care services for people living with disabilities in the region under the Disability Inclusive Development (DID) inclusive eye health (IEH) project.

3.3 Sampling technique

The study population includes different clusters of people with disabilities, including those who are most often marginalised due to the nature of their impairments and the interplay with other factors, such as gender, age, language, religion and more. It also includes family members of disabled people, community stakeholders and

health care workers. The study adopted a purposive sampling method to select respondents for each of the three key areas of interest.

For key interest 1 (enablers and barriers to eye health care-seeking behaviour for people with disabilities), the team worked with members of organisations of people with disabilities (OPDs) in Kogi State to identify and invite various categories of disabled people (visually impaired persons, deaf persons, and those with physical, intellectual and mental health conditions) from the rural communities based on their availability and willingness to participate in the study. The disabled participants also gave feedback on some of the key issues under key interest areas 2 and 3. Disabled persons identified include a mix of those seeking eye health care services and those who are not.

Regarding key interest 2 (key insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities), OPD members also identified and congregated willing family members of people with disabilities, and key community actors for the study.

For key interest 3 (attitudes and behaviours of health facility staff towards people with disabilities), Sightsavers programme representatives at the zonal hospitals (Desk Officer, Hospital Management Board) identified various categories of health care workers (including doctors, nurses, laboratory staff and so on) to be interviewed.

3.4 Interview techniques and tools

The mixed-method (mini-surveys, FGDs and KIIs) technique was used to enable adequate analysis and triangulation of data. While the quantitative tools help to identify the factors responsible for the behaviour being analysed, the qualitative analysis is key to understanding the ‘why and how’ behind the enablers and barriers.

For the first study objective, focusing on people with disabilities, a COM-B screening behaviour tool was administered to respondents to understand the factors that enable or prevent them from seeking eye health services. The tool is a 5-point Likert scale ranging from “strongly disagree” to “strongly agree”, containing a series of behavioural statements on Capacity, Opportunity and Motivation. In addition, a mini questionnaire on demographics was also administered to the respondents to understand their socio-economic attributes. This mini questionnaire includes the Washington Group Questionnaire (WGQ) extended set to enable us to identify and categorise disabled persons correctly. To address the qualitative component, an FGD question checklist was used to interview and gain further insights from the respondents on the behavioural issues and other factors that affect their ability to access health care services.

On the second objective, a force field questionnaire was used to understand the stigma and social norms that define the health-seeking pattern of people with disabilities. The force field methodology involves five steps, including describing the proposal for change (in this case, social inclusion for disabled persons); identifying forces for or in support for the proposed change; identifying forces against the

proposed change; assigning forces – scoring each force from 1 (weak) to 5 (strong) according to the degree of influence each one has on the proposed change and adding up the scores for both sides; analysis and application. [19] Although stigma and social norms could constitute factors that enable or prevent people with disabilities accessing health care services, treating it as a sub-section enabled us to gain wider and deeper insights on the subject matter.

To address the third objective, a semi-structured questionnaire was administered to the health workers to understand their attitudes, behaviours and perception towards people with disabilities. The questionnaire also includes questions to gain further insights from health workers on the behavioural issues and other factors that affect the ability of people with disabilities to access health care services. During the chat with disabled people, under key interest 3, their experiences with the health care workers were also examined.

All the data collection tools (see **Annexe 3**) developed were reviewed and validated by the Sightsavers team before being used for the study.

3.5 Data collection

Data collection was designed using electronic channels to improve the overall quality of data used for this analysis. All quantitative tools developed were programmed into **KoBoToolbox** to facilitate electronic data collection. The KIIs and FGD sessions were administered using digital recording devices. All the respondents were interviewed in the zonal hospital premises in both Ankpa and Kabba LGA. Four (1 female, 3 males) trained enumerators administered the study tools, and sign language interpreters were recruited and trained to assist in interviewing hearing impaired respondents. Since all interviews were conducted face-to-face with the respondents, COVID-19 safety measures were adhered to (including social distancing of one metre, use of face masks and hand sanitisers) to ensure the safety of respondents and data collectors.

Table 2: Proposed sampled respondents across study locations

Respondent category	Gender	Sample size	Interview tools and techniques	Study location
Key interest area 1: To understand what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level.				
Visually impaired persons	Male	5-7 people	• Demographics survey • Disability classification survey • COM-B survey • FGD	Ankpa
	Female	5-7 people		
Deaf persons	Male	5-7 people	• Demographics survey	Ankpa

	Female	5-7 people	• Disability classification survey • COM-B survey • FGD	
Physical impaired persons and leprosy	Male	5-7 people	• Demographics survey • Disability classification survey • COM-B survey • FGD	Kabba
	Female	5-7 people		
Mental and intellectual	Male	5-7 people	• Demographics survey • Disability classification survey • COM-B survey • FGD	Kabba
	Female	5-7 people		
Key interest area 2: Key insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities.				
Family members of disabled people, community stakeholders	Male	5-7 people	• Force field questionnaire	Ankpa
	Female	5-7 people	• Force field questionnaire	Kabba
Key interest area 3: Attitudes and behaviours of health facility staff towards people with disabilities reflecting on their health outcomes.				
Health care workers at zonal hospitals	Mixed	10 people	• KII (semi-structured questionnaire)	Ankpa
	Mixed	10 people	• KII (semi-structured questionnaire)	Ankpa

3.6 Data analysis

On the first study objective, quantitative data analysis began with a descriptive analysis of the socio-economic attributes of the respondents. This was cross-tabulated by the different categories of disabled people interviewed. Next, the COM-B survey Likert scale data was analysed to determine the mean values of each model component. The mean for the responses for each individual COM-B model statement was categorised into Agree (3.5 and above), Neutral (≥2.5 and <3.5), and Disagree (<2.5), and ranked (biggest mean score as 1st). The feedback from the various FGDs and KIIs was analysed using qualitative means. Data collected via the recording devices was transcribed and analysed according to the different categories of disability. In each category, feedback from male and female groups was analysed further to determine emerging themes for each of the study objectives. All the factors mentioned by the respondents were consolidated and mapped into

the COM-B model. Finally, the key insights (disaggregated by gender) from each category of disabled groups were summarised.

Data from the second study objective on stigma and social norms that define the health-seeking pattern of people with disabilities was analysed using force field analytical techniques described in section 3.4 above. Elements that further explain the factors that enable or prevents people with disabilities from seeking health care were added to the analysis on objective 1.

For the third study objective, quantitative feedback from the health workers was analysed using descriptive statistics. The same Likert scale analysis method, described above, was used to examine responses on belief statements and constraints that influence people with disabilities' access to eye health care services. Content and thematic analysis was deployed in analysing the qualitative responses, insights obtained were used to explain the quantitative findings.

3.7 Ethical considerations

Before the commencement of data collection, the Sightsavers project team sought and obtained ethical approval for this study from the Health Research Ethics Committee, Ministry of Health, Lokoja, Kogi State (see **Annexe 3**). The project team also reached out to the leaders of the organisations of people with disabilities, intimated them of the study objectives and secured their buy-in. The OPDs were useful in grouping the various categories of disabled people into four groups.

On each interview day, before the commencement of data collection, the study team explained the purpose of the study to each respondent group and emphasised that anyone is free to decline participation at any time before or during the interviews. Thereafter, each respondent was asked to sign the consent form (see **Annexe 4**). During data transcription, analysis and reporting, all personal identifiers, including names and phone numbers of respondents, were removed to maintain the confidentiality of the respondents, as promised.

3. Findings and discussion

Table 3 below presents the precise number of respondents interviewed per respondent category and key interest area of the study.

Table 3: Actual respondents and groups interviewed, interview details and tools administered

Respondent category	Sex	Number of respondents	Location	Interview date	Interview tools and techniques used
Key interest area 1: To understand what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level.					
Visually impaired persons	Male	8 + 1 physically impaired	Ankpa	16-11-2021	a. Demographics survey b. Disability classification survey c. COM-B survey d. Focus group discussion
	Female	3 + 2 physically impaired			
Deaf persons	Male	7	Ankpa	16-11-2021	
	Female	5			
Physically impaired persons	Male	5 + 2 visually impaired	Kabba	18-11-2021	
	Female	5 + 1 visually impaired + 1 deaf			
Key interest area 2: Key insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities.					
Family members of disabled persons	Male	7	Ankpa	16-11-2021	e. Demographics survey f. FGD and force field question checklist
	Female	6			
	Male	4	Kabba	18-11-2021	
	Female	8			
Community stakeholders	Male	6	Ankpa	17-11-2021	
	Female	3			

	Male	5	Kabba	19-11-2021	
	Female	7			
Key interest area 3: Attitudes and behaviours of health facility staff towards people with disabilities reflecting on their health outcomes.					
Health care workers at zonal hospitals	Male	9	Ankpa	17-11-2021	g. Demographics survey h. KII (semi-structured questionnaire)
	Female	8			
	Male	6	Kabba	19-11-2021	
	Female	9			

The respondents and groups interviewed differed slightly from the original plan of action set in the methodology (see Table 3 above). For instance, while we aimed to interact with people with leprosy and mental and intellectual disabilities, the field mobilisers (the OPDs) couldn't find them. The team also interviewed some groups originally intended for a different LGA and increased the sample size of many respondent groups to ensure the generation of sufficient insights. Under key interest area 2, the families of people with disabilities were interviewed differently from the community stakeholders since most of them brought the disabled people for interview on day 1. This separation was also important as it enabled unrestricted expression of views by both family members of the disabled people and community members.

In all, 118 (42.5% female) people were interviewed, comprising 40 people with disabilities (42.5% female), 25 family members (56% female), 21 community stakeholders (47.6% female) and 32 health workers (53.1% female). Findings from the interactions with the different respondents, organised by the study's key area of interest, are presented below.

4.1 Key interest area 1

Findings regarding what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level are presented and discussed here. Sub-sections include respondent demography, disability classification, results from the COM-B model survey and findings from FGDs.

4.1.1 Respondent demographics

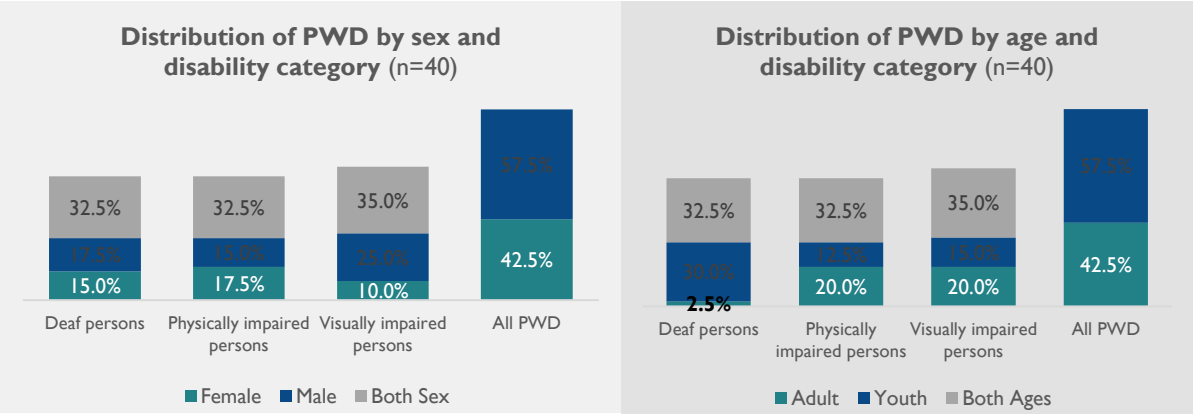

Figure 3: Distribution of respondents by sex, age and disability category

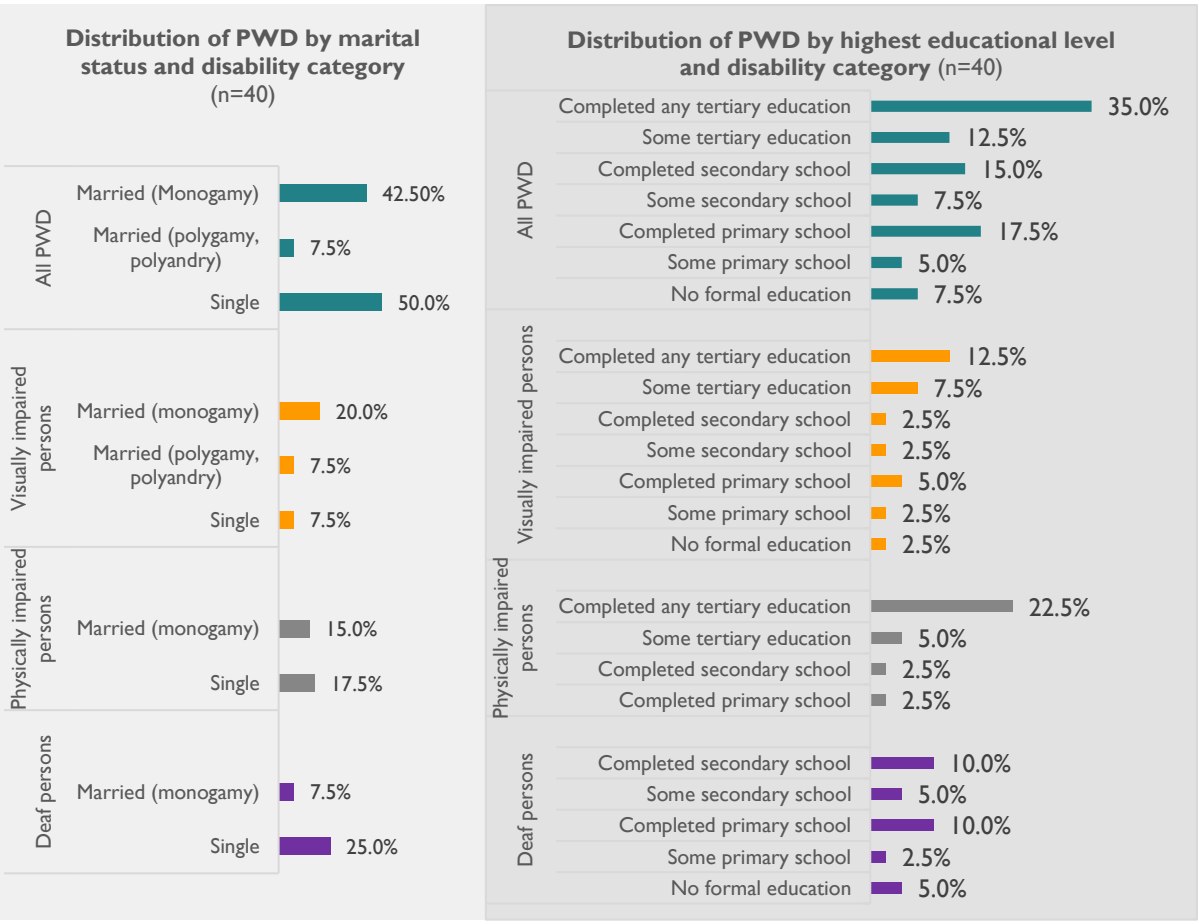

Figure 4: Distribution of people with disabilities by marital status, highest educational level and disability category

Of the 40 people with disabilities interviewed, 14 (35%) are visually impaired, 13 (32.5%) are deaf, and another 13 (32.5%) are physically impaired. As shown in **Figure 3**, more females (17.5%) were interviewed under the category of persons with physical impairment. Put together, of the 40 people with disabilities interviewed

17 (42.5%) are females. Also, 23 (57.5%) of the people with disabilities interviewed are youths (aged <=35 years), while 17 (42.5%) are adults. In terms of age category, the distribution is as follows: 21-25 years (15%), 26-30 years (25%), 31-35 years (17.5%), 36-40 years (7.5%), 41-45 years (15%), 46-50 years (2.5%), 51-55 years (5%), 56-60 years (5%) and 66-70 years (7.5%). More youths (30%) were interviewed among the deaf persons. The mean age of the respondents is 37 (with a standard deviation of 13.09); the minimum and maximum ages are 21 and 70, respectively.

Regarding respondents' marital status, 20 (50%) of the people with disabilities are married (monogamy, polygamy/polyandry). On the highest level of formal education, 14 (35%) of the respondents have completed tertiary education, five (12.5%) have done some tertiary education, and six (15.0%) have completed secondary school. Only 2.5% reported to have not undergone any formal education (see **Figure 4**).

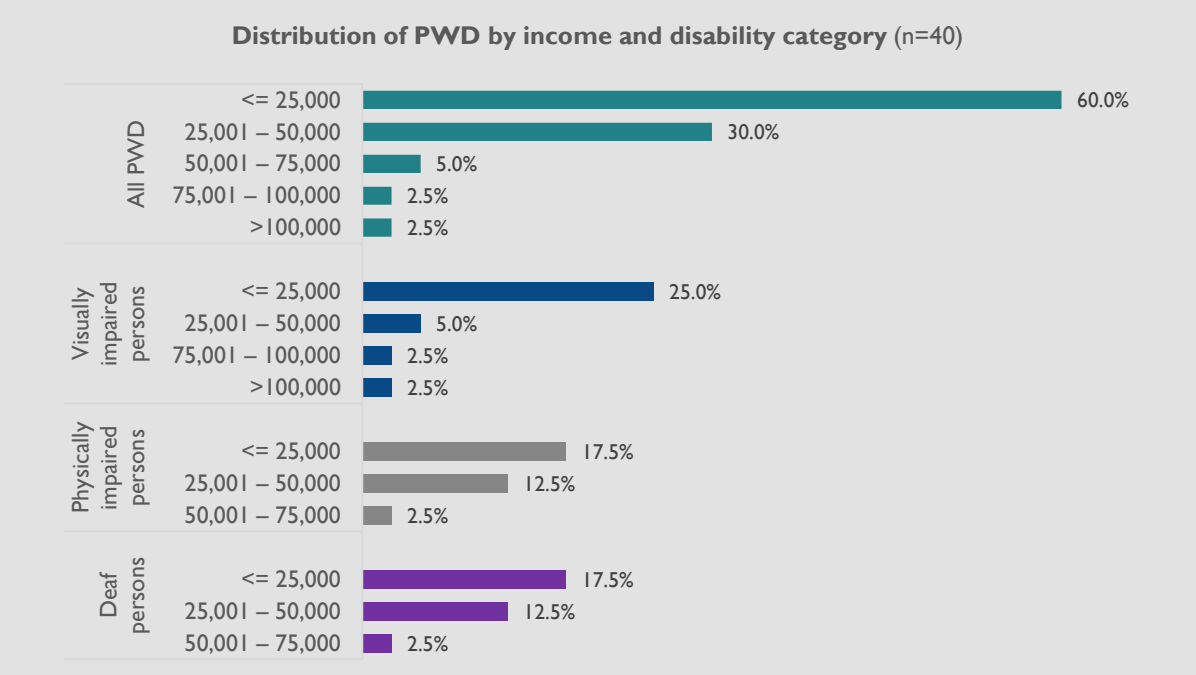

Figure 5: Distribution of people with disabilities by income and disability category

On average monthly income, the majority – 24 (60%) – of the respondents have an average monthly income of ₦25,000 or less, 12 people (30%) receive between ₦25,000 and ₦50,000, 2 (5%) get between ₦50,001 – ₦75,000. Only one person with disabilities (2.5%) receives above ₦100,000 monthly. The same trend of income distribution holds for all the different categories of people with disabilities, many of them, per category, earn/receive below ₦25,000 every month (see **Figure 5**).

4.1.2 Classification of people with disabilities

All the 40 respondents self-identified as people with disabilities (see **Figure 6**), however, the Washington Group short set enhanced questionnaire was also administered alongside, which indicated a 65% disability prevalence according to the Washington Group's classification on disability. Both the Washington Group short

set and enhanced set considered 65% to have a disability, respectively (per WGQ analysis procedure, respondents who mentioned that they have 'some difficulty' in any functional area were omitted). The disability prevalence was observed to be higher in females (54%) than in males (46%).

As the 40 participants self-identified as persons with disabilities before administering the WGSS, the team expected a high prevalence of people reporting functional limitations according to the WG limitations (potentially close to 100%). However, the 65% seems lower compared to expectations. Some explanations for this may be that, for example, people with certain physical impairments may not report limitations. However, this study is not focussed on exploring the difference between self-identification and the WGS. More research is required in this area.

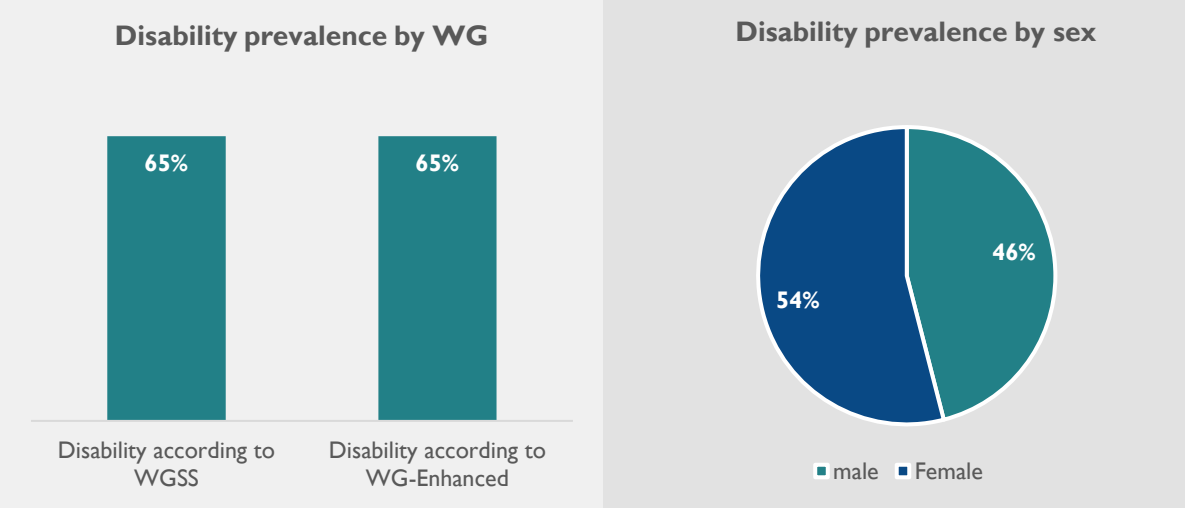

Figure 6: People with disabilities classification by WG and sex

Information in **Figure 7** indicates that difficulty in vision (25%) was reported most frequently among all respondents, closely followed by those with difficulty in communication (23%); 13% had difficulties in mobility and hearing, respectively; 5% had difficulty in cognition and the self-care domain, respectively: while 3% had difficulties with depression; and none of the respondents reported difficulty in the upper body (0%).

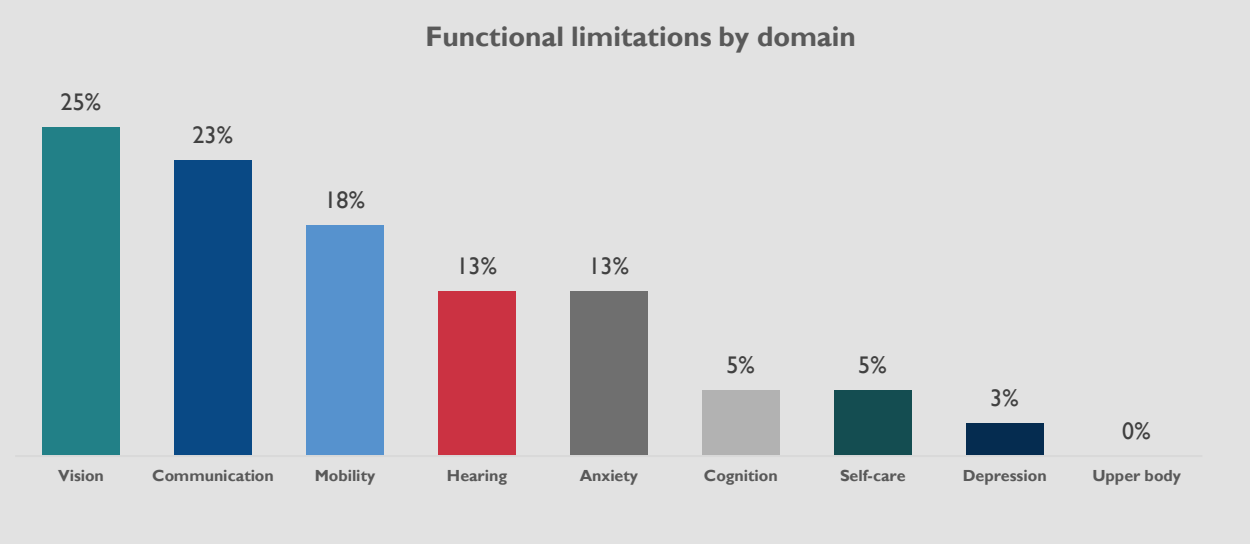

Figure 7: Functional limitations by disability domain

Patients may report more than one functional limitation and so would appear in multiple domains; therefore, the categories are not exclusive. Among those with a disability according to the WG enhanced, 19% (5) of them responded 'a lot' in more than one functional domain, indicating that they had multiple impairments. The proportion of those with multiple disabilities were all females.

4.1.3 Results from COM-B model survey

A COM-B questionnaire was administered to people with disabilities (visually impaired, deaf and physically impaired) to understand what enables or prevents them from seeking eye health care. As described in **section 3.6** above, survey data collected was analysed to determine the mean values of each model component. The mean for the responses for each individual COM-B model statement was categorised into Agree (3.5 and above), Neutral (≥2.5 and <3.5), and Disagree (<2.5), and ranked (biggest mean score as 1st).

Table 4: Analysis of COM-B responses on people with disabilities seeking eye health care

Behavioural statements	All people with disabilities		Visually impaired		Deaf persons		Physically impaired	
	Mean	Cat.	Mean	Cat.	Mean	Cat.	Mean	Cat.
1. Capability								
1.1 Physical capability								
a. I have the physical ability to get to an eye care centre	**3.73**	**Agree**	3.50	Agree	4.15	Agree	3.54	Agree

b. I need support to go through the process of receiving care in an eye care centre	**3.70**	**Agree**	4.14	Agree	3.62	Agree	3.31	Neutral
1.2 Psychological capability								
c. I know when I have an eye health problem	**4.20**	**Agree**	4.00	Agree	4.85	Agree	3.77	Agree
d. I am at risk of an eye health problem	**2.53**	**Neutral**	3.79	Agree	2.77	Neutral	2.15	Disagree
e. I am unlikely to have an eye health problem	**2.70**	**Neutral**	2.71	Neutral	1.92	Disagree	3.46	Neutral
f. I know when I need to go for eye health checks	**3.88**	**Agree**	3.57	Agree	4.46	Agree	3.62	Agree
g. I know where to go for eye health screening	**4.13**	**Agree**	3.50	Agree	4.77	Agree	4.15	Agree
h. I know why I need to go for eye health screening	**4.03**	**Agree**	3.36	Neutral	4.85	Agree	3.92	Agree
2. Opportunity								
2.1 Physical opportunity								
a. There are eye health centres in my community or surrounding communities	**3.73**	**Agree**	3.57	Agree	3.38	Neutral	4.23	Agree
b. The available eye health centres are close to my residence	**3.03**	**Neutral**	3.21	Neutral	2.69	Neutral	3.15	Neutral

c. I have enough time to go for eye health checks	**4.28**	**Agree**	4.50	Agree	4.15	Agree	4.15	Agree
d. I have enough time to go for eye health treatments	**4.25**	**Agree**	4.43	Agree	4.15	Agree	4.15	Agree
e. Eye health checks are affordable for me	**3.03**	**Neutral**	2.29	Disagree	3.77	Agree	3.08	Neutral
f. Eye health treatment is affordable for me	**2.78**	**Neutral**	2.00	Disagree	3.31	Neutral	3.08	Neutral
2.2 Social opportunity								
g. Available eye health care centres do not support my specific needs	**3.05**	**Neutral**	3.57	Agree	2.69	Neutral	2.85	Neutral
h. I have a friend or family member diagnosed with eye disease or defect	**3.05**	**Neutral**	3.14	Neutral	2.46	Disagree	3.54	Agree
i. Our culture supports screening for eye disease or defect	**4.05**	**Agree**	3.93	Agree	4.46	Agree	3.77	Agree
j. Most people in my community go for eye screening	**3.25**	**Neutral**	2.50	Neutral	3.77	Agree	3.54	Agree
k. We have a family practice of taking care of our eye health	**2.75**	**Neutral**	2.79	Neutral	2.69	Neutral	2.77	Neutral

3. Motivation								
3.1 Reflective motivation								
a. I do not think there is anything I can do to protect my sight	**2.75**	**Neutral**	2.79	Neutral	2.54	Neutral	2.92	Neutral
b. I believe that screening for eye health is beneficial	**4.68**	**Agree**	4.71	Agree	4.85	Agree	4.46	Agree
c. I am afraid of being diagnosed with any eye disease or defect	**3.08**	**Neutral**	2.79	Neutral	3.46	Neutral	3.00	Neutral
3.2 Automatic								
d. I think eye health is important	**4.65**	**Agree**	4.64	Agree	4.62	Agree	4.69	Agree
e. I think eye health is less important than other parts of my health	**1.73**	**Disagree**	1.71	Disagree	1.77	Disagree	1.69	Disagree
f. I want to be more proactive in protecting my sight	**4.43**	**Agree**	4.36	Agree	4.69	Agree	4.23	Agree
g. Those who go for eye health screening receive some incentives	**3.35**	**Neutral**	3.14	Neutral	3.77	Agree	3.15	Neutral
3.3 Others								
h. Eye health is more important to a man than a woman	**1.70**	**Disagree**	2.14	Disagree	1.08	Disagree	1.85	Disagree

i. People with formal education are more likely to go for eye screening	**3.55**	**Agree**	3.93	Agree	3.15	Neutral	3.54	Agree

Table 4 contains the aggregate and disaggregated responses from the three (3) categories of people with disabilities respondents regarding the various COM-B statements posed to them. Details of their feedback, as per the COM-B model component, are explained in subsequent paragraphs below:

On **Physical Capability** (capacity to engage in the necessary physical processes), the majority of all the three groups of people with disabilities stated that they have the physical ability to get to an eye health screening. When asked if they need support to go through the process of receiving care in an eye health centre, both the visually impaired and deaf participants largely agreed that they do, while physically challenged participants were mostly undecided.

Regarding **Psychological Capability** (capacity to engage in the necessary thought-comprehension, reasoning), most of the respondents said they know when they have an eye problem. Those who are visually impaired agreed that they are at risk of an eye health problem, those who are deaf were unsure, while those physically impaired disagreed. When asked if they are unlikely to have a health problem, the visually and physically impaired persons were undecided, while the deaf persons disagreed. All the people with disabilities agreed that they both know when and where to go for eye health checks. Additionally, while the deaf and physically impaired agreed that they know why they need to go for eye health screening, those who are visually impaired were unsure.

In terms of **Physical Opportunity** (opportunity afforded by the environment), both visually and physically impaired persons agreed that there are eye health screening centres in their community or surrounding communities; deaf persons were unsure. The people with disabilities were undecided when asked if the available screening centres are close to their residence. They also agreed that they have enough time to go for an eye health check and treatment. On whether eye health checks are affordable, mixed responses were received as visually impaired respondents disagreed, deaf respondents agreed and physically impaired respondents were undecided. When asked if eye health treatment is affordable to them, visually impaired persons also disagreed, whereas deaf and physically impaired persons were unsure.

Talking about **Social Opportunity** (opportunity afforded by the cultural milieu that dictates the way that we think about things), both deaf and physically impaired people gave a neutral response when asked if the available eye centres support their specific needs; those visually impaired agreed. When asked if they have a friend or family member diagnosed with eye disease or defect, visually impaired people were unsure, deaf people disagreed, while physically impaired people agreed. All the respondents agreed that their culture doesn't prevent them from

screening for eye disease or defects, and all of them were undecided when asked if they have a family practice of taking care of their eye health. On whether most people in their community go for screening, those who are visually impaired were unsure, while other people with disabilities were affirmative.

Concerning **Reflective Motivation** (involving evaluation and plans), all the respondent groups were not sure of their ability to protect their eyesight. However, while they unanimously agreed that screening for eye health is beneficial, they were undecided when asked if they are afraid of being diagnosed with any eye disease or defect.

About **Automatic Motivation** (emotions and impulses arising from associative learning and/or innate dispositions), all classes of people with disabilities agreed that eye health is important to them, disagreed with the statement that eye health is less important than other parts of their health, but agreed that they want to be more proactive in protecting their sight. On whether those that go for eye health screening receive any incentive, people who were visually and physically impaired were unsure, while deaf people agreed that incentives were provided for hospital visits.

Regarding the **Other Factors** explored in all categories, the respondents disagreed that eye health is more important to a man than a woman. On the role of education, both visually and physically impaired persons agreed that people with a formal education are more likely to go for eye screening; deaf persons were unsure.

4.1.4 Findings from focus group discussions

4.1.4.1. Visually impaired persons

Two FGDs were completed for visually impaired persons; the section below contains feedback from both male and female FGD discussants.

Perception on the importance of the eyes

Respondents were asked to explain how important it is to seek care for their eyes. As shown in Box 1, both male and female respondents in Ankpa LGA affirmed that the eye is a vital sensory organ. They also agreed that loss of eyesight brings untold hardship, stigmatisation, and discrimination even from family members, hence, the need to seek eye care early.

Male visually impaired – Ankpa	Female visually impaired – Ankpa
“The eye is like a headlight which shows you where you can go and gives you direction to carry out a needed task”	“It is very important to seek care for the eyes because without your eyes, you can hardly move again”
“The eye is a pivot which helps other parts to function properly and tells much about one’s personality, which affects how one feels and gains confidence. People value you only when you do have your sight and without the sight,	“It is very important because, without the eyes, you can't do anything at all. People will easily cheat you because you can't see what they want to do to you. But when you have eyes, you'll see anything that's coming

people tend to look down on you and cut off relationships, even among family members, because they feel you have become a liability to them”	your way and you will be able to do almost everything” “Eye health is very important. Now I can't see because I am visually impaired. I can't do a lot of things until I am directed”
“Also, seeking eye-care early could help you not to lose your sight completely and it is very important to take care of their eyes to avoid discrimination” “I was once told by a doctor that I can never regain my eyesight again and that gave me depression and currently on medication”	“Eye health is very important because, without the eye, it is like you are not in the world at all. You will not be able to do things like normal people” “Seeking care for eye health is important because, without the eyes, you can't witness anything. You are easily cheated; people laugh at you and mock you just because you are visually impaired, and this causes a lot of pain”

Box 1: Extracts from FGD transcripts – Visually impaired males and females in Ankpa LGA

Factors that prevent people with disabilities from seeking eye health care

When asked to explain what prevents people with disabilities from seeking eye health care, some of the main factors mentioned by the male respondents in Ankpa LGA include ignorance of the emerging symptoms, inadequate finance to support the cost of treatment and even access to the health care centre, loss of hope and belief that there is no cure or remedy for their eye condition, and fear of being stigmatised and discriminated against. Other factors, considered as minor, include difficulty in accessing the hospitals – an experience shared by other visually impaired persons.

The female respondents also re-echoed some of the points raised by their male counterparts. They identified and ranked the issues of inadequate financing/low standard of living, loss of hope, and discouragement from people to be the top three crucial factors preventing them from seeking eye health care. Inadequate support they get from people to assist them to move around was ranked as the least crucial factor, but significant for some respondents, nonetheless.

Precise responses from all respondent groups are presented in Box 2 below.

Male visually impaired – Ankpa	Female visually impaired – Ankpa
“Ignorance is the major reason that prevents people from seeking eye health care because they mistake early signs of the diseases to poor nutrition, lack/irregular sleep, effects from being tired or just dizzy, and lay complains and request for treatment on what they think rather than visiting certified eye health clinics for proper eye screening” “Ignorance of knowing that your eyesight is very important to your well-being and fear of discrimination from non-visually impaired persons is a factor” “Not wanting to be identified with the visually impaired due to the level of stigmatisation on the visually impaired” “Having the mindset that it’s a waste of time and money because they think there is no remedy or cure for their ailments since people around them who have these problems had little or no help from getting healed” “Lack of money is the reason that most people are discouraged to go to hospitals for a check-up and to get money from other means is difficult due to the feelings that they can’t compete with those who are not blind, they can’t adjust to their new condition and also to get assistance from people is difficult due to resentment of their current condition” “Religious belief is also a factor as some feel they do not regard other religions different from theirs with the doctrine that they are not worthy or consider them unclean. Others won’t want to be part of facilities owned by a religion different from theirs even if it is accessible for fear of being rejected or given non-preferential treatment”	“The first thing that comes to my mind is the lack of assistance, I don't always have people to help me move around. A lot of disabled people live alone. Like me, when I need to go to the hospital, I do not have someone to assist me to help me get to the hospital. As a result, I have to remain at home whether I like it or not” “For me, I think the major hindrance is the issue of lack of finances. Apart from eye health, if you do not have money, it will stop you from doing the things you want to be doing. Now talking about eye health, people place importance on it but if they don't have money that's the end. When disabled people don't work because of their condition, they're not able to afford a level of decent livelihood. Some are not well fed not to talk of going to the hospital. So, it is the case of not having enough money for day-to-day living, more so going to the hospital” “Some people have lost hope in their condition. They have gone to several hospitals and health facilities and they can't see any improvement in their health, therefore the person is discouraged from going to seek care or attention” “Also, some people are discouraged by the people around them, like the family members or community members of the person. Some people tell them that they're just wasting time and resources going to the hospital, saying nothing can ever change their predicament. The community don't have faith that the condition of the people (person) involved can ever be cured. So, the challenged persons themselves begin to believe nothing can be done”

“Loss of hope by visually impaired persons that nothing can be done to restore their sight was due to multiple consultations with some negative feedback, which discourages people with early eye problems not to continue seeking for eye health care until it gets worst” “Doubt can set in when one does not agree with the interpretation of the screening result, thinking whether one will only waste money without any progress and also fear of financial implication may arise with the thought that the cost of the care is not affordable” “Environmental factors such as bad roads discourage the people with disabilities, especially the visually impaired who do not like to follow routes with difficult terrains and obstacles from accessing eye health care, and distance from the communities also comes into play when the people with disabilities are not financially buoyant or don’t have good means of transport” “Other people’s philosophy influences other people with disabilities to create fear on this medical care, these people say that the situation can be made worst if care is not taken”	

Box 2: Extracts from FGD transcripts – Visually impaired males and females in Ankpa LGA

Factors that enable people with disabilities from seeking eye health care

Similarly, the respondents were asked to explain what enables them to seek eye health care. The top three factors identified by the male respondents include the need to maintain/regain eyesight and avoid stigmatisation and discrimination and gain acceptance into the community, availability of health care facilities, and support from family and community. Other enabling factors identified include enlightenment from health care workers and the availability of health personnel.

The female respondents ranked having finances/a decent living standard to be the most crucial factor; the second most crucial factor was the encouragement of people around them and in their community. Having prompt and ready assistance from

people was ranked third, faith in God fourth and then support from churches and organisations were ranked the least crucial.

Male visually impaired – Ankpa	Female visually impaired – Ankpa
“The urge to regain sight has made many seek health care quickly with the knowledge from what they see the impaired go through which is pathetic. So, the motivation to consult these facilities drive them to an extent they go long distances to be helped”	“The most prominent is the issue of finances/standard of living of people with disabilities. When people have money, they wouldn't think twice before going to the hospital for a check-up for their eyes. It is just the opposite factor mentioned above. Once people have the funds, it's easier to go and even join the long queue just to get well. This means the availability of funds will encourage people with disabilities to seek eye health care”
“The visually-impaired know that one’s status drops in the society when they have issues with their sight and therefore, will want to change their status back to normal at all cost”	“I still think that when we have people to readily and promptly assist us in moving around, we will easily go to the hospital. But when you want to go and the person who is supposed to be assisting you just tells you that they're coming, sometimes before you see them, till the time is gone and you can't go again. They do that because they want to dodge the stress of moving you around. So, the availability of people who are willing and ready to assist, either in person or providing equipment, it is going to be helpful to us”
“When people get the understanding and enlightenment on the need to seek eye care from NGOs and volunteers, seeking for health care becomes a priority to them, either to prevent the situation from getting worse or prevent it from occurring when they don’t have it at all through regular screening and check-ups”	“Even though we have people that will discourage you from going to the hospital, some people will still tell you to go for eye health check-up, tell you that all will be okay and you feel a little better to face your challenge and go to the hospital. Especially organisations like "Reconciler", work with a Christian organisation and usually hold medical outreaches and health seminars. They have programs that encourage us to pay attention to our eye health. Those kind people in the community encourage us to go to the hospital for our eye health”
“Support from family and community members has encouraged others to seek medical help knowing they will get long time support since the families are the ones who encouraged them in the first place. One’s self-esteem is built when one knows he/she is accepted by those who matter most in their lives”	
“Many try to avoid stigmatisation from others, like changing their names to blind “X” rather than their real names has prompted others to seek help in special facilities in due time when diagnosed of these challenges”	
“Available and accessible health care centres and health personnel indicates that people don’t contemplate going there either confidently or discreetly. When people see these facilities close to them,	“Some people believe that God can heal them at any time. So, they keep encouraging themselves to keep going to the hospital. Their faith is what keeps them going, they'll be praying but still, they'll be

they tend to easily and or routinely go for screening and check-ups due to the notion that it has reduced financial cost or at least eliminate the cost of transportation” “The need to normalise, that is, to feel normal again which is to return to moments when they do not feel pains, struggle, loss of confidence, independence and depressed, drives them to seek for care at all cost until all hope is lost. People usually do not wish to lose anything, and sight is very key to survival. It is a great feeling to do things your way and by one’s self without the interference of others or their show of sympathy” “The need to be accepted back in the community has made others seek help in the eye health clinics because immediately one has issues with their sight, others kind of isolate them, which is as a result of fear of getting infected as people spread false information which has no basis. So, the need to feel among or accepted in the society again drives them to visit these health care centres”	going to the hospital. For me, I am optimistic that God will change my story one day, that's why I keep coming to other the hospital over and over again” “Churches do hold seminars and medical outreaches. Sometimes they encourage people to go to hospitals for a further check-up after the church have done a medical check-up and diagnosed them with a problem. When they do this for free, it gives us an idea of our problem and as they encourage us to go to the hospital, we feel like there's hope. They do this for everyone, whether they have an eye problem or not”

Box 3: Extracts from FGD transcripts – Visually impaired males and females in Ankpa LGAs

4.1.4.2. Deaf persons

Likewise, the study team completed two FGDs for male and female deaf persons in Ankpa LGA; feedback from both sessions is summarised in the following sections below.

Perception of the importance of the eyes

The respondents (both male and female deaf persons) opined that the eye is the most important part of the body. For them, it is important to take care of the eyes for various reasons, but most importantly because they are already deaf. Losing their eyesight will amount to double jeopardy as they won’t be able to see sign language interpreters. Detailed responses in this regard are rendered in box 4.

Male deaf persons – Ankpa	Female deaf persons – Ankpa

“It is important for one to seek care for eye health because you may not have noticed the signs and symptoms (pain) from the eyes. It is better one knows the cause of the problem and take appropriate action. The eye is the most important part of the body, if there are signs of illness on the eyes, one should look for the solution before it gets out of hand” “It is very important to seek eye health care so that he will not have double disabilities. If a sign of pains or itching emerges from the eye, it is the matter of going out to seek for the solution…” “Brighter eyes are very important. God did not create anybody with blindness. So, as a student or young person, having an eye infection is a problem. Because of that, if I have any problem with the eye, I will run to the doctor or any specialist to find the solution to the eye problem”	“It’s very important to me because without the eyes, I cannot see” “My eye health is very important to me. Because without my sight I cannot be able to see and understand sign language, because we communicate with our eyes, so if we can’t see then we can’t communicate, and that will only make our situation worse” “It is very important. Without my eyes, I can't be part of anything that is happening in this world, I'll be left out since already I can't hear”

Box 4: Extracts from FGD transcripts – Deaf males and females in Ankpa LGA

Factors that prevent people with disabilities from seeking eye health care

When asked to detail the factors that prevent people with disabilities from seeking and accessing eye health care, the male respondents identified the top five reasons as: the attitude of health care workers, inadequate experts in the hospital (including sign language interpreters), expired medications from the hospitals, inadequate facilities, medications, and inexperienced personnel at the hospitals. Other factors mentioned include: inadequate orientation on health care issues, inaccessibility to the health care facilities, lack of support from the government, some societal culture and norms (that restricts youths and women from seeking medical attention on their own or that recommends that children born blind be killed to avoid other children developing blindness), and personal beliefs of health staff facilities.

The female respondents agree that the inability of health workers to understand them is the most crucial reason why they do not come to the hospital. Other crucial factors include the stigma they face and inadequate finances to cater for themselves and seek health care.

Male deaf persons – Ankpa	Female deaf persons – Ankpa
"…maybe the medical personnel may not understand the nature of the eye problem of the people with disabilities because he is not a specialist, and the specialist who is supposed to treat the patient is in a different hospital, the one here without the expertise or experience will try to treat the person with visual impairment, he/she may end up worsening the situation" "When it comes to the prescription of drugs, if the doctor/nurse is not there, other people who are not experts e.g., ward attendant may like to prescribe the drugs. Taking these drugs may not improve the condition and may get worse" "Doctors should be experts even in approach while dealing with people with disabilities or human life. If a doctor is not patient enough and he is coming with annoyance to the hospital, sometimes, when you are talking to him, he will transfer aggression on you, not minding the condition you are coming with. Such unprofessionalism will prevent one from getting assistance from that facility" "On the sign language interpreter, we, with hearing impairment are not like any other physically challenged person. It takes a sign language interpreter or doctor who understands our mode of communication. In a situation whereby I come to the hospital with complaints because none of my relatives, followed me and the doctor does not understand what I am saying because the provision of a sign language interpreter was not made, then I will only be making noise or disturbing the health staff. This again is preventing us from seeking eye health care in the hospital"	"What discourages me from coming to the hospital, not just for eye health care but for any other health challenge is lack of effective communication. Most of the time, there are no sign language interpreters in the hospital and as such, I can't even communicate my plight to the doctors or nurses because a lot of them do not understand. On a few occasions where you will find a sign language interpreter, some of them will hardly understand what I am trying to pass across. I end up leaving angrily. I prefer going to the chemist seeking first aid" "Yes, I agree that it is hard to communicate with health workers when we come to the hospital. Sometimes, we don't have anybody in the house to go to the hospital with us to assist us in telling what our problem is and since they won't understand us in the hospital when we try to communicate, its discourages us from seeking for health care" "Also, sometimes we get so weak and hungry and because we don't have enough money to even feed and do-little things, we get discouraged that we can't even afford the cost of eye health care, even if we start having signs and symptoms of eye problems"
"In this case, when you have a particular eye problem and decide to visit the clinic close to your residence, you may likely be referred to another health facility centre where may be far away from your residence and you may not have the	"Personally, one of the things that discourage me is the way people look at me in the community. Sometimes people see me as if I am not of value to society. Sometimes, lack of finance to take care of myself makes me look like a burden when

money to transport yourself and even afford the bills from the hospital…”

“Lack of sign language interpreter. There are moments where our family members will refuse to take us to the health facility, from our nature, we need a sign language interpreter to interpret what we shall be saying to the doctor. The doctor may not understand what I am saying, someone like a sign language interpreter must be there to tell the doctor comprehensively, what I am saying. The failure to provide one prevents me from seeking eye health care from the hospital”

“From the perspective of the physically challenged and those with visual impairment, if the hospital environment is not accessible, it prevents them from seeking for eye health care. What accessible here means is that, at the planning, designing and building of the hospital, these categories of people with disabilities should be put into consideration in the sense that, story buildings should not be built as they cannot access it due to their health challenge”

“Sickness can never be seen as a friend to anybody, this means that eye specialists should always be there for them to always and easily attend to our health challenge. Eye specialists are not accessible because their number is small in the state and country. Again, doctors on their part, move from one hospital to another working just to make money. Because they are busy, we don’t easily meet them to present our case, this makes them inaccessible”

“Culture has a lot to do with human life. Some cultures believe that the young visually impaired, should not on their own, go to seek medical assistance except their parents. Assistance here means, going to the hospital facility to see a doctor and telling him/her about my health problem so that medication can be given. For example, I have an eye problem now, culture demands I must first tell my father

I ask anyone for money, or when I go to the hospital without money they treat me like I am nothing, they won't even attend to me. To make some money, I usually make hair for little girls in the community so that I can have some money to buy things for myself, but I still will not be able to go to the hospital because the money will still not be enough”

“We also suffer rejection from our friends because of our condition, like me for example, my friends have run away from me, even the way they look at me, I feel like I am alone in this life and I have nobody. There was a time I used to have a lot of friends and I had a business I was managing but because of the Nigerian economy everything has changed, my business has failed, my friends have run away from me because I have to ask them for money so they don't even come around me anymore. I stay alone which causes me a lot of pains because I don't have anyone to gist with or to even go to the hospital with me” “Sometimes I suffer a lot of pain, stomach ache, headache but I don’t have money and I can't ask friends. It’s difficult to even go to the hospital because won't answer me without money, that is if they're able to understand what I'm saying”

and explain everything about my hearing impairment even when he may not understand what I am saying, in doing all these, the condition becomes worse. But if I can be allowed the opportunity to go to the hospital and a sign language interpreter is there to interpret my lines to the doctor or any person, I will be happy. Some parents will abandon you and go about their usual activities"

"Some cultures believe that women should not go out of the house alone for reasons like not to be seen by other men. Now if the woman is having an eye problem, since there is a belief that women should not go out, the woman has been tied down at home and her condition will continue to go bad. The tendency for the medical doctor to leave the hospital and come to the house and attend to her is not there as most families are not rich enough to hire a family doctor. Now if the male family members are not caring, to avail time and take this woman to the hospital, then she stands a chance of developing serious eye issue"

"In those days, when one is born with blindness or infection, there is a culture that says, such a child should be thrown out of the house, into the river, so that the other family members will not contact eye problem and it becomes hereditary. If one is unfortunate to have such a child, they prefer to keep them in the room always, with serious limitations to their movements and involvement with people. The mother will not want to see her labour thrown into the river just like that, she will take care of her baby for a while, after which she will find a way and sneak out the baby to another community"

"What I mean by the belief is that belief in society cannot be easily eradicated. If medical personnel have a belief despite the training, he/she received, that belief will go on affecting people. For example, Apollo (acute haemorrhagic conjunctivitis) is believed to be a communicable disease,

everyone knows this. If a patient comes to the hospital with this eye problem, such a person will hardly be attended to, he or she will discriminate against the person”

“When you come to the hospital and the doctor prescribes a drug for you, the moment you get to the pharmacy, you will not find the drug in that hospital, you are left with the option of going to the chemist to buy at an expensive price”

“Lack of manpower. The government again have failed to recruit manpower needed in the hospital. The hospitals are seriously lacking staff. When you get to a government hospital, you meet only one doctor. How will one doctor adequately attend to all the patients in the hospital?”

“Sometimes the drugs needed are not in the hospital, they can only prescribe to you to buy from the pharmacy outside the health facility. Again, the pharmacy might be far away from the health facility, and probably before the relatives come back, the patient would have died. This is because the government fail to do its bidding well”

“In those days, there are clinics in every community or ward where you live. So that when you are ill, you can easily be attended to. Then the doctors and nurses moved around the communities sensitising people on what to do and what not to do, to stay healthy and avoid certain diseases. Today, this practice is no longer there, and people are ignorant of many health issues and all these have caused them problems. Some of the doctors will not stay in the public health facility, they will rush to their private facility”

“As it is often said, ignorance is a disease, as I am, I am not a doctor neither a pharmacist nor any health staff but a layman. Anything given to me by a doctor, nurse or pharmacist is correct, there are a lot of expired drugs in the hospitals. If such drugs are administered to me, I would not know because I cannot read, so instead of

recovery from the illness, the expired drug will complicate issues the more which can lead to death”	

Box 5: Extracts from FGD transcripts – Male and female deaf persons, Ankpa LGA

Factors that enable people with disabilities to seek eye health care

In this section, the male deaf persons talked mostly about what will help increase the number of deaf persons and other people with disabilities to seek out eye health care services. Key issues identified centred on the need for government to capacitate the hospitals in terms of providing sign language interpreters, trained specialists, requisite equipment, medications and so on.

The female respondents agree that seeing someone around them going through a hard time with their sight is likely the most crucial reason why they would go to check their eyes. Many of them have not deliberately sought to access eye health care in the past.

Male deaf persons – Ankpa	Female deaf persons – Ankpa
“If the health facility has experienced personnel, that is a well-trained specialist, who will avail our time, it will encourage us to go and seek for eye health care in the facility” “If the facility is accessible by the act of having a sign language interpreter, I can go to the facility and seek eye health care. For without this, I cannot be understood”	“Sincerely, because of your (Sightsavers) programmes, with time if we should have any health challenges, we will go to the clinic because we so much believe in you people that you people will provide all that you have been asking us and we have been responding and we believe that with the help of this organisation we will be encouraged to come to the clinic”
“Government should provide all that will motivate us to go to the facility to seek for care. They include recruiting specialists in eye care, providing all the needed tools for personnel to work with, stocking the pharmacy with good drugs that are not expired. These provisions will encourage me to go and seek eye health care”	“Before Sightsavers, I was brought to an eye clinic a long time ago. This was because I saw a drama on the TV, I couldn't hear them but I saw what was playing out on the TV and a girl was having the same challenge and they took her to the hospital. That made me tell my parents to take me to the hospital because I am having the same problem as the girl on the TV” “I have been coming to this clinic before, but not the eye clinic, it was when my mother collapsed and was rushed to this clinic that I found out there was an eye clinic because they were going to check

	her eyes. Her eyes had a problem. That made me check my eyes, apart from that no one/nothing has encouraged me to come to the eye clinic to come and check my eyes” “I have not been diagnosed with eye problem before, therefore I don't see why I should be coming to check my eyes meanwhile my disability is hearing impairment. So, I don't have anything that motivates me to come to check my eye, I have never checked it”

Box 6: Extracts from FGD transcripts – Male and female deaf persons, Ankpa LGA

4.1.4.2. Physically impaired persons

Two (2) groups of physically impaired persons (males and females) were also interviewed in Kabba LGA through FGDs, with the findings presented below.

Perception of the importance of the eyes

All the respondents interviewed affirmed the importance of their eyes to their wellbeing. They also recognised the need for regular eye checks, especially where symptoms emerge to halt any possible progression to loss of eyesight. Transcribed notes on this conversion are presented in box 7 below.

Male physically impaired persons – Kabba	Female physically impaired persons – Kabba
“It is very important because as the saying goes, the eye is the light of all other the body, it is, therefore, good to check the status of the eye to know what is wrong with it, this can be done in the eye clinic, just this eye clinic provided by Sightsavers” “To seek for eye health is too important because by doing that you get to know what exactly is wrong with your eye, you may be having short-sightedness or long-sightedness, but you cannot just go to the market and buy lenses that are recommended by opticians for you to get proper solution to your eye problem, you have to seek care/treatment from professionals, and it not good leave you eye problem until it is bad before you treat it” “It is important to seek eye health in other to avoid complications, it is not enough or good to seek for eye health just about anywhere but consult only professionals and trusted health care facilities like this one provided by Sightsavers” “Again, we all are different, so also are our eyes, eye A may be able to manage his eye problem for a long time while eye B can only manage it for a very short time, therefore it is important to take care of the eye and check it regularly to ensure that it remains good(healthy), or any problem is treated immediately before it gets worse”	“It is very important to seek care for my eye health so that the eyes will not be damaged completely. Especially if someone already has an eye problem, seeking care for the eyes will help the person to understand how he/she can treat the eyes right on time” “It is very important because, without the eyes, you can't do anything. The eyes are the light of the body” “It is important because seeking for care will prevent any eye problem from getting worse to an advanced stage, and it'll be treated promptly” “The eyes are what keep us moving in life. That is why it is important to seek care for them, else one will not be able to move”

Box 7: Extract from FGD transcripts – Male and female physically impaired persons, Kabba LGA

Factors that prevent people with disabilities from seeking eye health care

In summary, the male respondents identified several factors they believe are responsible for the low patronage of eye health care centres by people with disabilities. The top four factors identified include: inadequate finance to support access to eye health care in terms of paying for transportation, consultation and treatment; proximity to the health care facilities; the attitude of health workers and the general public (stigmatisation); and ignorance about eye health care by people with disabilities. Other factors mentioned include: inadequate structures to aid

mobility (bad roads; lack of requisite facilities/mobility supportive structures in the hospitals); and absence of health care facilities.

The female physically impaired persons, in a similar manner to their male compatriots, ranked the high cost of hospital bills and having little to no money as the most crucial factor that prevents them from going to eye health care centres. This was followed by ignorance on the importance of seeking eye health care, and carelessness or nonchalance with one's health.

Male physically impaired persons – Kabba	Female physically impaired persons – Kabba
“Well one of those things that prevent us from seeking eye care is money, you know, most of us don’t work, and for those that do we are limited in the number of jobs we can do, and most of the jobs we can do are not high paying jobs that can cater for our needs and health care, so you see that we depend largely on our family members to provide money for our transport, consultation and event treatment” “Another thing is the attitude of the health care service providers, they look down on disabled persons, when they attend to fully able-bodied persons, they tend to forget about people with disabilities or don’t attend to us on time, this is stigmatisation that stems from beliefs about people with disabilities from the general public, health service providers are part of the general public this belief is that people with disabilities are less important in the society or sometimes not useful” “In most rural areas eye care health facilities are absent” “Before now the proximity to eye health care facility is a very big barrier, since to for eye problem you have to be referred to Kano or Kaduna of which most of us can’t afford the transport fare to go that far”	“The cost of getting treatment from the hospital is expensive. I don't always have the money to foot the bills. My house is far from the hospital, taking a bike to and fro is already one expense, then I have to pay to be attended to at the hospital. I was working before; I have discontinued the work. Now, if someone comes to the hospital, the person has to buy a card, then see the doctor, then pay for drugs. For someone who is not working, I am not able to come to the hospital regularly. And I lost my job because of my disability, it was difficult for me to go continue working so I had to stop and that is why I am not able to afford to go to seek for eye health care regularly” “In my case, I have not seen the need to go to the hospital seeking eye health care because my eyes never gave me problems. My eyes are fine, with no symptoms of eye problem so I never imagined that I need to seek eye health care given the state of my eyes” “Some people are just basically nonchalant towards their overall health. Some can have symptoms of eye problems, but they'll not go to the hospital simply because the pain is manageable. They may have the money, but they'll still not come to the hospital, expecting that it will just go since it is a mild symptom they're having”
“Another thing is that there’s no proper orientation of the health workers on how to handle people with disabilities and this discourages us to come to health care	“…what the last speaker said is true. Like me, I've been having a lot of symptoms of eye problem, it itches me but I have not come to the hospital to check even though, after this discussion I'll go to the eye centre

facilities whenever we imagined the stigma of how bad we could be treated” “Mere coming to register for and eye check we have to pay ₦500 for a card that alone, this discourages me, maybe if they can subsidise it to ₦100, I can afford that, after the test they are now recommending drugs for me to buy which is another cost” “Accessibly to these health facilities is key, most of the roads to these facilities are not motorable, this is a major discouragement, especially to people with disabilities that don’t have assistance from family, friend or the community” “Another thing is ignorance on the path of people with disabilities, not many of us know the importance of seeking for eye health care, and to an extent, some of us have given up on ourselves, written ourselves off, and conclude that there is no remedy to the situation, but generally the level of enlightenments about the need to seek eye health care in people with disabilities is very low”	here but it's been disturbing me for long and I have just been postponing going to the hospital because it has been mild” “I have not had any problems with my eyes, just like the other speaker. So, I have not even seen any reason to go to seek for care for my eyes”

Box 8: Extract from FGD transcripts – Male and female physically impaired persons, Kabba LGA

Factors that enable people with disabilities to seek eye health care

In Kabba LGA, the top three supportive factors mentioned by visually impaired males include: individual financial capability (those who have enough funds are also willing and able to seek eye health care); desire to regain or maintain good eyesight; being proactive against loss of eyesight; support and encouragement from health educators and family members; availability of eye health care centres; enlightenment provided to people with disabilities; and availability of free medical services.

The female participants ranked severe eye defect symptoms as the most crucial factor, and free and subsidised treatment as the second most crucial factor that motivates seeking eye health care. They ranked awareness of the importance of seeking eye health care as the third, having a habit of going to the hospital as the fourth, and the kindness of health workers as the least.

Male visually impaired – Kabba	Female physically impaired persons – Kabba
“The desire to have good sight drives me to seek eye health, you can practically do	“When the cost of treatment is subsidised or made free, it'll encourage people to come to

nothing if you don’t have good eyesight, by this I believe eyesight is more important than hearing”

“The presence of this eye clinic by Sightsavers motivates us to come for eye health care, we believe they are professionals and the equipment are there”

“For me, it is because I have the confidence that I can afford the eye health care, that’s why I look for it”

"Sometimes we move with the crowd, if people are trooping to go for eye check especially free eye checks organised NGOs and politicians, this influences us a lot”

“Another thing is enlightenment for people with disabilities to see the importance of seeking for eye health care”

“Sometimes our families and eye health caregiver/educators encourage us to seek for eye health”

seek for care. At least, we'll only have the transport cost to deal with, knowing that the cost of treatment in the hospital will not cut off our heads”

“Another factor that motivates people to come to seek for eye health care is when the symptoms of eye problems are severe. With or without money, people will come to the hospital when the problem becomes severe. In Africa, we like doing this a lot, we won't treat a problem when it is still mild until it is becoming unbearable”

“In my case, I'll say that now that I have been told on the importance of checking my eyes at regular intervals, it will motivate me to be going to the hospital for a check-up. And I learned about its importance in a training that was held in this hospital two days ago. I believe that when people are aware of the importance of going to seek eye health care, they'll be more encouraged to go for it”

“Also, free medical outreaches motivate people to go to seek care for their eyes. When there are medical outreaches organised in the community, you will see people who on a normal day will not go to the hospital going for a check-up. This is something that enables people to go to seek care for their eye health if they are diagnosed with eye problems, they are usually administered treatment there, or they'll refer them to a hospital to receive treatment”

“Most of us here are not visually impaired, that is why we are not specifically talking about seeking eye care. But the way some medical personnel treat us with care encourages us to come to the hospital. Even if you don't have money, they'll give you words of encouragement and that alone will lift your spirit. Some others will talk to you disrespectfully, making you wonder if you

	brought your disability on yourself. But the kind ones make me come back” “Some people have a practice of going to the hospital from time to time. It is like a habit for them. These do not need anything to encourage them, they already live their lives going for a check-up”

Box 9: Extract from FGD transcripts – Male and female physically impaired persons, Kabba LGA

4.1.5 Discussion – Factors that influence eye health care-seeking behaviour of people with disabilities

Results from the COM-B survey were triangulated with findings from the different FGDs, with key insights presented below.

People with disabilities agreed that they have the physical ability to get to an eye care centre, they know when they have an eye health problem, they know when and where to go for an eye health check. The respondents also agreed that they know why they need to go for eye health screening but need support to go through the process of receiving care in an eye care centre. This ‘support’ was further highlighted and defined during the FGD sessions to include financial aid (covering transportation fares, cost of care and treatment and cost of medications), guides – especially for those with visual impairment, and interpreters at the hospitals for those who are deaf.

The people with disabilities confirmed the availability of eye health centres in their communities although at varying proximity depending on their location of residence. They also confirmed they have enough time to go for their eye health checks and treatments. Again, the constraint of finance emerged as the respondents were undecided about the affordability of both eye check-ups and treatment. During the FGDs, a respondent mentioned that because most of the people with disabilities are unemployed, it is difficult for them to use their meagre resources allocated primarily for feeding to pay ₦500 for hospital cards alongside other costs to be incurred going to the hospital and potentially receiving treatment.

It was also obvious that social dynamics impact the decision of people with disabilities to go for eye health screening. While the respondents agreed that their culture permits them to go for eye health care, they were unsure if the available health centre can support their needs. They could neither confirm if people in their community go for eye screening nor if they have a friend or family member diagnosed with eye defects. They were also undecided on if their families have a practice of seeking eye health. It is therefore important to note that if there is no culture among people without disabilities to go for eye health checks, people with disabilities may lack the motivation or inspiration to adopt this behaviour. Enlightenment interventions perhaps could also be extended beyond people with

disabilities to create a community-wide social change that will become a ‘pull’ factor to the target populace.

Regarding motivation, although people with disabilities believe that both eye health and screening for eye health is important, they want to be more proactive in protecting their eyesight, however, they were unsure if there is anything they could do to protect their eyesight. This uncertainty presents an entry point for appropriate social behaviour change interventions.

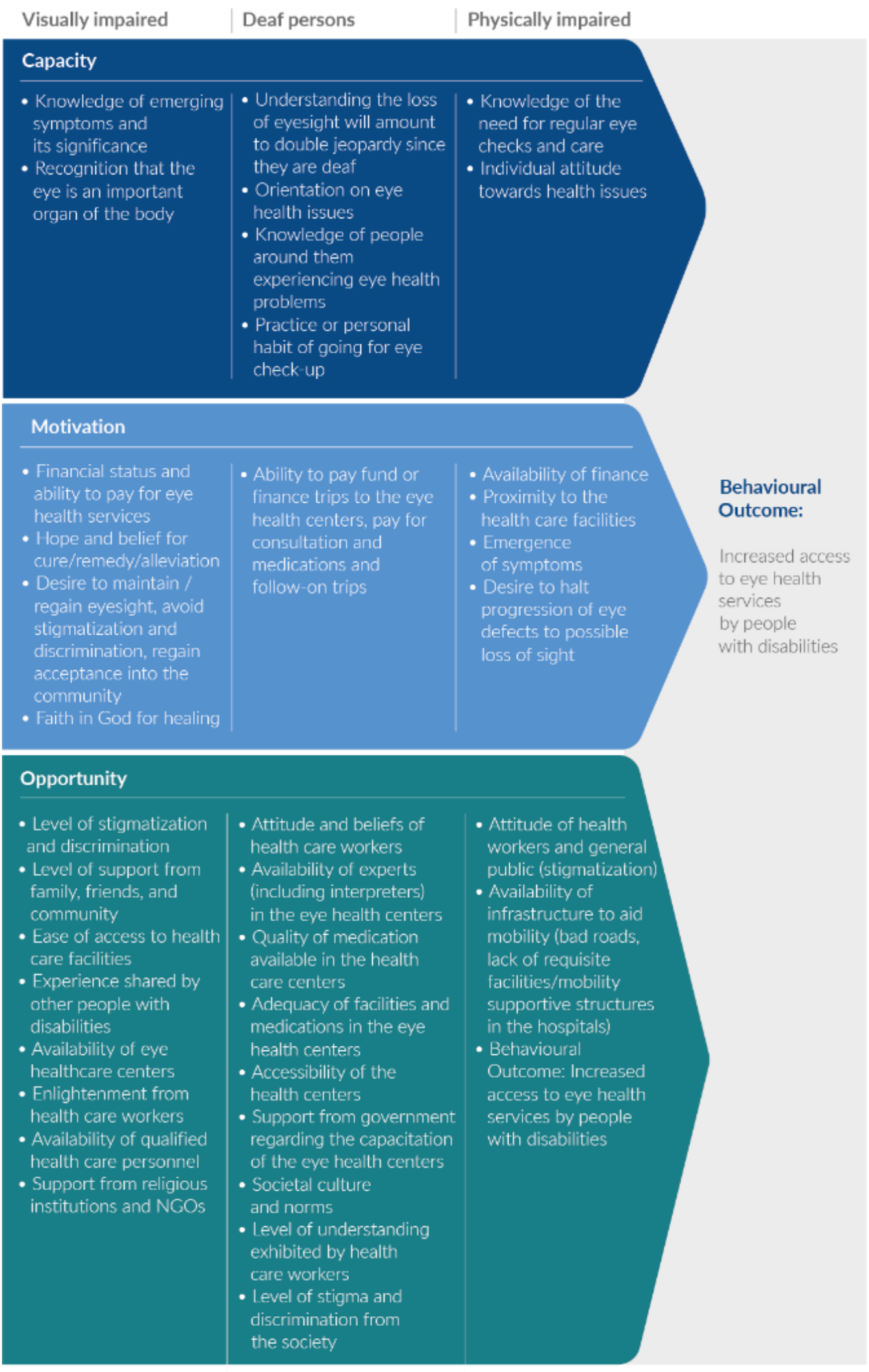
Visually impaired
Deaf persons
Physically impaired
Capacity
• Knowledge of emerging symptoms and its significance
• Recognition that the eye is an important organ of the body
• Understanding the loss of eyesight will amount to double jeopardy since they are deaf
• Orientation on eye health issues
• Knowledge of people around them experiencing eye health problems
• Practice or personal habit of going for eye check-up
• Knowledge of the need for regular eye checks and care
• Individual attitude towards health issues
Motivation
• Financial status and ability to pay for eye health services
• Hope and belief for cure/remedy/alleviation
• Desire to maintain / regain eyesight, avoid stigmatization and discrimination, regain acceptance into the community
• Faith in God for healing
• Ability to pay fund or finance trips to the eye health centers, pay for consultation and medications and follow-on trips
• Availability of finance
• Proximity to the health care facilities
• Emergence of symptoms
• Desire to halt progression of eye defects to possible loss of sight
Behavioural Outcome:
Increased access to eye health services by people with disabilities
Opportunity
• Level of stigmatization and discrimination
• Level of support from family, friends, and community
• Ease of access to health care facilities
• Experience shared by other people with disabilities
• Availability of eye healthcare centers
• Enlightenment from health care workers
• Availability of qualified health care personnel
• Support from religious institutions and NGOs
• Attitude and beliefs of health care workers
• Availability of experts (including interpreters) in the eye health centers
• Quality of medication available in the health care centers
• Adequacy of facilities and medications in the eye health centers
• Accessibility of the health centers
• Support from government regarding the capacitation of the eye health centers
• Societal culture and norms
• Level of understanding exhibited by health care workers
• Level of stigma and discrimination from the society
• Attitude of health workers and general public (stigmatization)
• Availability of infrastructure to aid mobility (bad roads, lack of requisite facilities/mobility supportive structures in the hospitals)
• Behavioural Outcome: Increased access to eye health services by people with disabilities

Figure 8: Mapping of findings on factors that influence access to eye health care services by people with disabilities, using COM-B model

Insights from the focus groups discussions regarding the factors that influence the eye health care-seeking behaviour of people with disabilities were summarised and mapped against the COM-B model as well (see **Figure 8**).

Under the Capacity domain, while all people with disabilities acknowledged their recognition of the importance of their eyes as a driving force that influences them to seek eye health care, deaf persons additionally mentioned the fact that they can't afford to lose another critical sensory organ. Other shared factors highlighted under this component include the knowledge of emerging symptoms and their significance (an understanding that some symptoms indicate serious defects which can lead to blindness if untreated), and individual attitude towards health issues (like those with a natural habit of going for periodic health checks are more likely to go for eye health checks).

For Motivation, a central theme emerged across the different disability types. All people with disabilities highlighted finance as a crucial factor that determines if they go for eye checks or not. Many of the respondents noted the fact that they have limited funds as many are unemployed, and support from family and friends is limited. Recall that 60 per cent of the people with disabilities interviewed receive no more than ₦25,000 monthly from all sources (see **Figure 5**). Funds received are mostly dedicated to feeding and upkeep. For a typical hospital visit, money is needed for transportation, the registration fee, consultation fee,

and purchase of medications and follow-up visits.

Several common factors emerged under the Opportunity component of the COM-B model. Chief among them was the impact of culture, stigmatisation and discrimination, which was regarded as both a deterrent and an enabler. For some people with disabilities, seeking eye health care services is important to ensure they don't lose their sight and hence become stigmatised and discriminated against. For others, stigma and discrimination are key preventive factors as they prefer to remain at home rather than face stigmatisation. The attitude of health care workers was also highlighted as a key influence by both visually impaired and deaf people. Availability of supporting infrastructure (that facilitates ease of access to and within the hospital premises) and expertise (qualified health care workers who are supportive and able to encourage and enlighten them) at the health care centres were also mentioned. Concerns were raised by deaf persons on the availability of interpreters to help them communicate with the health care workers, while visually impaired participants mentioned the contributions of religious bodies and NGOs who organised free medical outreaches as opportunities they often tap into.

4.2 Key interest area 2

Findings on key insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities are presented and discussed here. Sub-sections include respondent demography, FGD findings and force field analysis.

4.2.1 Respondent demographics

For key interest area 2, information in **Figure 9** shows that 46 respondents (52.2% females, 24) were interviewed across Ankpa (23) and Kabba (23) LGAs. Of this 46, 54.3% (25) are family members of disabled persons, while 45.7% (21) are stakeholders in the communities where people with disabilities interviewed earlier (under key interest area 1) live. Of the 25 family members, 30.4% (14) are females. 21.7% (10) of the 21 community stakeholders are females.

In terms of age category, the majority of the respondents are adults 60.8% (28), with youths making up 39.1% (18). The mean age of respondents is 40 years (with a standard deviation of 13.95), the minimum age of the respondents is 16 years, while the maximum age is 67 years **(Figure 10*)***.

The majority (89.1%, 41) of respondents mentioned that they interact with people with disabilities at least once a week, 8.7% (4) interact with them at least once every two weeks, while 2.1% (1) interact with people with disabilities at least once every three months or more. As expected, family members had the most 54.3% (25) frequent interactions (once a week) with people with disabilities than community stakeholders **(Figure 10*).***

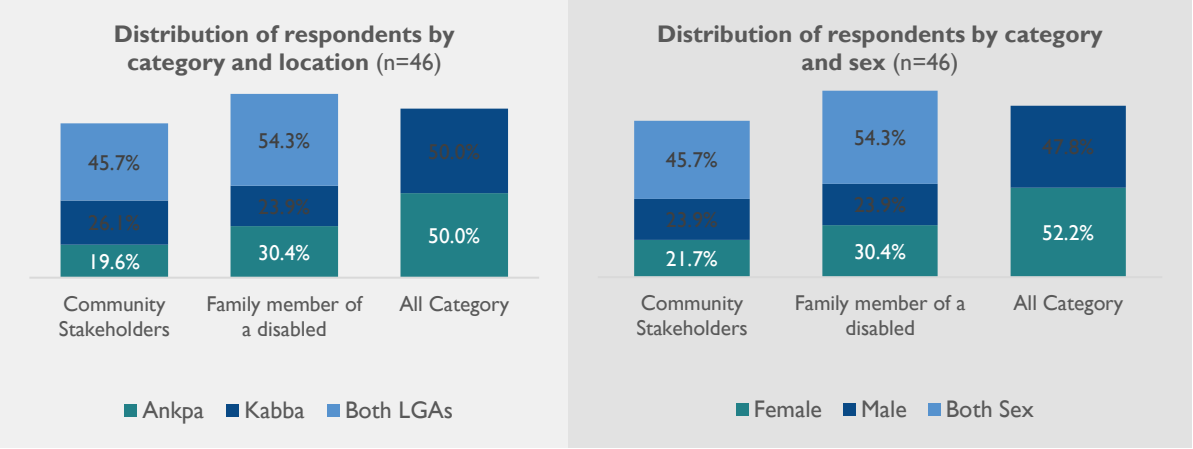

Figure 9: Demographics of respondents – Family and community stakeholders, by location and sex

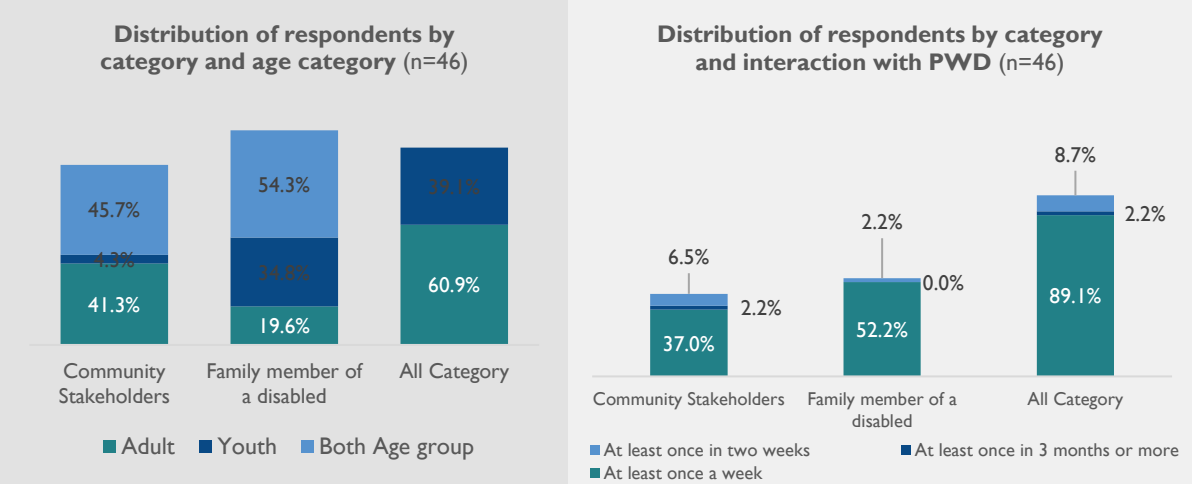

Figure 10: Demographics of respondents – Family and community stakeholders, by age category and interaction with people with disabilities

4.2.2. Findings from FGD and force field enquiry

4.2.2.1. Family members of people with disabilities

The study team held four FGD sessions with family members of disabled people; the sections below contain feedback from both male and female FGD discussants in Ankpa and Kabba LGA.

Stigmatisation of people with disabilities

The respondents were asked if people with disabilities face any form of stigmatisation (seen and labelled differently from people without disabilities) and, if so, to give insights on the underlying reasons. In summary, responses confirmed that people with disabilities face a lot of stigmatisation from family, friends and community dwellers. Findings (illustrated in subsequent paragraphs) also show that the stigmatisation of people with disabilities is largely driven by misguided beliefs, mischief, ignorance and a range of other contextual issues.

For instance, some people are afraid of being afflicted with the disability – this fear is driven by superstitious beliefs (perceived punishment and wrath from the 'gods' for his/her wrongdoings or those of the parents/relatives) or religious beliefs. Others believe that disabled people are liabilities since they can't function optimally. It was also highlighted that perhaps the biggest form of stigmatisation comes from within the people with disabilities themselves, as they generally have low self-esteem/an inferiority complex and believe they can't contribute as much as others to society. This, of course, correlates with the way they are seen and the manner in which they are treated by people without disabilities.

In a bid to make disabled people comfortable, many tend to stay away from them. In community meetings, the views of people with disabilities are often disregarded without due consideration because people feel that the disability may have affected their sense of judgement. The fact that many disabled people don't have much education also contributes to their views being overlooked. A point was also made

about the fact that many disabled people are not wealthy, hence, it is easy for the thoughts and opinions of people with disabilities to be ignored as people typically pay more attention to the voice of the wealthy.

Specific answers given by the respondents are detailed in Box 10 below.

Male family members of people with disabilities – Ankpa	Female family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
“Yes, they do face stigma like, for example, so many people sometimes are afraid to share common objects with physically challenged people because they feel that they could be afflicted with the same condition, or even worst. The fears come from superstitious beliefs …people believe that the person with a disability could be cursed by the gods for something they might have done or not done, as such any association with them is dangerous” “Yes, because people see people with disabilities as not equal to them (lower class), since they can’t do some basic things like chores (wash the dishes, sweep the room, wash clothes) around the house, and thus they are seen as a liability”	“Yes, people with disabilities face stigma in the community. I think that the most prominent form of stigmatisation they face is the stigma they feel towards themselves, from themselves by themselves. They tell themselves that they wish they were like normal people, but every human being is normal, disabled, or non-disabled” “My sister, for example, will always cry whenever she comes back from school. She has hearing impairment; she can't hear what the teacher says or what other students are saying. She also can't talk to them too. It makes her worry a lot, thinking about herself as an abnormal human being and she thinks so low of herself, thinking she is not up to her other classmates”	“The issue of misconception comes in play since due to cultural beliefs, any form of misfortune is as a result of wrath from the gods, even when someone becomes disabled at a later stage in life, it might be as a result of karma, either from their evil act or from that of their relatives” “These cultural beliefs affect others born with these disabilities with the notion that the people with disabilities are evil spirits incarnated in human forms and so, should be avoided at all cost, that is if they survived being eliminated at a tender age. People with disabilities are constantly reminded that they do not have a place in society and will never be accepted”	“Yes, they do. I say so because, in the community, people generally do not regard people with disabilities. Some people don't interact with them, some don't want to come close to them. People perceive them as if they are nobody or even less than humans. Sometimes you see people not wanting to sit in the car/vehicle with them, some will not want to eat around them, all because they feel irritated at people with disabilities. There was this wedding I attended, there was a disabled man and the people sharing food kept passing by him to serve others. When he asked for food, they discarded his request as if he meant nothing or he is a nobody. That's an example of the kind of stigma they face in a public gathering”

“Yes, many at times especially in the case of HIV, the “normal people” run away and distance themselves from people with disabilities because they think that they could contract the virus; this comes from misinformation about the virus, because mere shaking of hands, or sitting with HIV patient can’t get one to contact the virus”	“This stigma springs up from the people with disabilities themselves, and this is as a result of the various kinds of experiences they have outside in the community which makes them feel so low of themselves” “Also, in this community, people try a lot not to make disabled people feel bad by keeping away from them, but you will still see some people not wanting to relate with them, keeping their distance away from them because of several beliefs. Some don't eat where people with disabilities are eating, some will forfeit seats in a vehicle because a person with disabilities is in the vehicle. Some people think a disability is a spiritual problem, so they don't even want to associate themselves with them. Some even believe that it is a communicable disease” “Actually, in this community, churches and mosques discourage people	“People often disassociate themselves from the people with disabilities and at times these actions come from family and friends” “Even during community gatherings, their inputs to prevailing issues are not accepted because the people feel they are not complete, it has affected their ability and so, they won’t have a full sense of judgement. Also, most people with disabilities are not well educated since they never went to good schools or dropped out at one time or the other in their lives, they will have little to contribute” “Other causes of these stigmatisations is that the people with disabilities are not wealthy due to their disability and hence are not regarded in the society, where he stated that people are more respected in most society is relative to the level of their financial income” “People with disabilities often	“Most of the family members of the people with disabilities on the other hand have accepted them because they have finally accepted that they will have to live with the person with a disability and they can't change it” “Some family members of the people with disabilities don't accept them. Some parents prefer to buy things for children that are not disabled those with disabilities. Some find ways to do away with such a person but since they can't, they mistreat the person so that the person feels bad for being someone with a disability. So, we can say that people with disabilities face stigma in the community in places like car parks or eating spots, in public gatherings like weddings, and sometimes in the family/home”

	from stigmatizing people with disabilities, because they are seen almost everywhere in the community. You see children making fun of physically challenged people, and even running away from them. Even though the churches and mosques discourage stigmatization, people with disabilities are still stigmatized in the community. Some people may not say it out or show it but in their minds, they'll never agree to do things with people with disabilities, they look at them in a bad way. I have heard of places where they think that people with disabilities are cursed or they are a punishment on the land, but it is not in this community though, you just hear different stories of different beliefs"	have self-pity (inferiority complex) and this kind of stigma is self-inflicted, this occurs because the people with disabilities themselves lose hope, think they can't function optimally and constantly remind themselves that they are different. This feeling can have a link to what has been said to them or how they were once treated by non-disabled persons"	

Box 10: Stigma to people with disabilities (source: transcripts from FGDs with male and female family members of people with disabilities in Ankpa and Kabba LGAs)

Discrimination of people with disabilities

Following the discussion on stigma, the respondents were then asked if people with disabilities face any form of discrimination (treated differently from people without disabilities) and to give specific examples if true. It was evident from the responses (see box 11) that people with disabilities are discriminated against by some family members, friends and community dwellers.

Instances of discrimination mentioned include denial of job opportunities on the account of the disability rather than qualification (fuelled by the conviction that the people with disabilities will struggle to perform on the job); denial of admission into schools due to lack of specialised equipment to support learning for people with disabilities; and inadequate capacity of tutors in this regard. Other manifestations of discrimination of people with disabilities mentioned based on perceived inadequate capacity include: exclusion from games/sporting activities and events; denial of marriage; separation from their children; denial of full entitlement and wages; disregard of their opinions; being ignored or made an object of mockery by people without disabilities, and so on.

Male family members of people with disabilities – Ankpa	Female family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"Yes, because often people with disabilities are deprived job opportunities even when they have the required qualifications, just because employers think that if they employ the people with disabilities, they can't perform in the role efficiently"	"When it comes to discrimination, I'll say that in my family, we don't discriminate against my sister, or even other people with disabilities, because we have someone like them at home. Instead, we give them more attention than non-disabled people because we understand that they have special needs"	"People with disabilities are discriminated by being deprived of positions in the society despite being qualified either educationally or through the positive impact they must have contributed to that community" "People with disabilities are also denied marriage, where people think they can't take care of themselves talk more of taking care of others" "Other people with disabilities are ripped off from their children and this affects the people with disabilities greatly"	"People with disabilities are being treated badly in school because of their disability. Especially in schools where the students are quite young. These pupils choose to play with other pupils that are non-disabled rather than the people with disabilities. Some of them are scared of people with disabilities, some just make fun of them for what they look like or what they do not have"

“Yes, sometimes people with disabilities are denied admission to schools because the schools don’t have the special equipment required to teach people with special needs and even the teachers lack the required skills to teach the people with disabilities” “Yes, because people with disabilities are sometimes excluded from many activities such as sports and games because they are thought of as incapable to perform even if they can place such games or sports”	“People with disabilities require special treatment and my family has taken it up to give my sister all the support and care that she needs. She thinks too much, she overthinks. If we discriminate against her, it will only get worse and we won't get to understand her in the house again. It's the same thing with other people with disabilities” “I have more examples of how people with disabilities have been helped more than examples of how people with disabilities have been discriminated. Like in churches or mosques, it is a regular practice to help people with disabilities to go and sit in the front of the gathering, other people give them that honour. The reason is so that they will not feel bad”	“There are established cases where governments, donor agencies or NGOs provide support to the people with disabilities, the aids often get diverted and only a very small portion or nothing is handed over to the people with disabilities and these acts often demoralise them” “There are cases of people with disabilities not being paid their entitlements (full) in various establishments, this is due to the thought that they contributed less (due to their disability, they can’t function maximally) to achieve a certain goal” “People leave gatherings when they see these people with disabilities on grounds that they are out of place and sometimes because they look un-kempt” “Since most people with disabilities have no financial strength of their own, they do not get regarded since the public see them as liability or nuisance. People often regard them as “beggars” or they	“Sometimes, people are being discriminated against based on their disability. Like for someone who has a hearing impairment, people can just be insulting the person anyhow because they know the person can't hear. For those who have visual impairment, people like to cheat on them because they can't see. This mostly happens in the community surrounding people with disabilities. For instance, my sister has a hearing impairment, the headmistress of the school that her children attend wanted to take advantage of her disability to make her pay twice for the children's graduation gown, but although my sister doesn't hear, she couldn't allow the woman to do what she wanted. The headmistress felt my sister would forget, thankfully she remembers vividly”

		could slow down or stop the non-disabled from living their normal lives since they have to stay back and assist the people with disabilities"	

Box 11: Discrimination of people with disabilities (source: transcripts from FGD with male and female family members of people with disabilities in Ankpa and Kabba LGAs)

Forces that promote acceptance and inclusion of people with disabilities

Respondents were then asked to identify the forces that drive or support total acceptance and support for disabled people in their households and community. Points mentioned (see **Box 12** for detailed feedback from the respondents) include an individual's conviction to do good; religion and faith (which counters superstitious beliefs) – where clerics preach the acceptance of people with disabilities and make people see it as a religious obligation; level of education and skills exhibited by some people with disabilities; wealth status of people with disabilities; and personal experience of having people with disabilities within one's family.

Male family members of people with disabilities – Ankpa	Female family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"What drives me to support or help people with disabilities is that I believe that if I help someone in need, somebody else will help me too when I needed. I believe this not because some tells me but because I practice it and it works for me"	"The first thing I'll say is that people have human feelings. They acknowledge that God created everyone equally, both able and disabled. When we do not accept them, we cause them to harm themselves by believing that they are less than others"	"Religious sympathy has helped greatly in the sense that when clerics emphasise the need that the people should accept the people with disabilities and make them see it as a religious obligation. The people with disabilities are easily accepted because these followers can be so religious not to reject the instructions of their clergies"	"Some of these people with disabilities are not accepted because of the beggarly attitude they have. That's why sometimes, people don't regard them. If these people are taken out of the streets and stop begging, it is going to go a long way in helping people accept them"

“As for me why I am supportive to people with disabilities is because I know and understand that they are important too, we once have a ward councillor who is physically challenged, and he did well” “People with disabilities are part of our families and we are closest and available to help, it is only right to support them. If we don’t help them nobody will. They can’t come here by themselves”	“Acceptance and support are determined by a personal conviction that people with disabilities are equally like us, needing all the love and support and care that can be given” “Religion and faith matter a lot too. When people have the fear of God, they will know that people with disabilities are not spiritual cases of any punishment from God. Those who fear God accept them, and they help them in their places of worship”	“The level of education and self-worth of some people with disabilities have given them acceptance as they often have unique abilities not found even among the available non-disabled persons. Exposure and vast knowledge from these people with disabilities have also helped to re-integrate them into the society because people will want to see them not as liabilities but assets” “Wealth also is a force that when a disabled person has it, it will make him/her accepted by the community simply because they are no longer seen as a liability”	“If people with disabilities are provided for and taken care of, they won't be in the streets begging and people will begin to accept them when they fend for themselves” “When people develop a culture of love, they'll accept people with disabilities. Some people are so compassionate about humanity that they see people with disabilities and they only think of how to help them” “Some people that have people with disabilities at home, when they see other people with disabilities outside, they can understand the struggle they go through and they help them in any way they can to make life a bit easier for them”

Box 12: Forces that promote acceptance and inclusion of people with disabilities (source: transcripts from FGD with male and female family members of people with disabilities in Ankpa and Kabba LGAs)

Forces against the acceptance and inclusion of people with disabilities

Conversely, the respondents were asked to characterise the forces that promote the rejection and exclusion of disabled persons in households and the community. In summary, the following issues were identified (see **Box 13** for direct quotes from the respondents), including communication problems (inability to establish a conversation with some disabled people); entrenched cultural beliefs which drive superstitious and traditional beliefs, including real fear that they could get the condition if they don’t stay away; individual temperament, wickedness and

perceptions; genuine ignorance (not driven by cultural beliefs) of causes of disability, which is mostly medical or health related; personal traits of people with disabilities, including their appearance, dressing and wealth/poverty status.

Male family members of people with disabilities – Ankpa	Female family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"Why people find it difficult or do not support people with disabilities is because of communication problem, when you can't understand somebody, you can't help that person, or at best the help you render is limited, for example, if I am a health personnel and a deaf person comes to me, and I don't understand sign language then you will see that I can't support/help that deaf person" "One thing that makes people not to support people with disabilities is the belief that associating with them will re-incarnate their condition in one's family"	"People's ignorance plays a huge role here. They are ignorant of the fact that people with disabilities can naturally come as a result of medical or health issues, not as a punishment or a curse. Like I mentioned earlier about the people that believe that people with disabilities are spiritual cases or curses, their culture is what informs them. Long existing cultural beliefs have a huge part to play against accepting people with disabilities. Some cultures make them be banished, some will make them be mistreated"	"Cultural beliefs have been a major factor in this part of the country where people are not enlightened to know that disability has no relation with spirituality but a form of deformity. Innocent persons have been killed, abused and even rejected due to cultural point of view in the society" "Shabby appearance and inadequate proper self-care has made most people with disabilities not to be accepted in most communities because naturally, people see them as disgusting when they appear dirty in other to attract sympathy from passer-by for their financial needs (to receive alms)"	"Some people are just so ignorant. Some people believe that people with disabilities are bad luck to the community or the family, or they are products of the promiscuity of their parents. But most of these cases are not associated with these beliefs. Those who hold these beliefs are ignorant of the real causes of disability" "I think people are just being wicked. They will just see people with disabilities and mistreat them without cause, even if they haven't offended them" "Sometimes, the attitude of people with disabilities also makes people not to accept them. Some people with disabilities see as if they can do no wrong at all in their own eyes"
"Fear, people are afraid that worst	"Another thing is even the stigma we	"Lack of finances affect how these	"They mistreat people and that in

condition will befall them if they associate with people with disabilities. Even in our culture, we believe that nobody should greet people with leprosy even from a distance” “You see, different people have different temperaments which make them behave towards people with disabilities the way they do, you will see that people with hot temper usually get upset quickly or get frustrated when trying to communicate to persons with hearing impairment, and could react badly towards people with disabilities, so temper is a force that makes people mistreat people with disabilities”	are talking about. The perceptions of the community against people with disabilities will make the community not to accept them since they have a negative perception that they are less of humans than they are” “It can also be just pure wickedness. People decide to mistreat people with disabilities just like that, without the people with disabilities offending them or without them holding any beliefs. So, it can be personal or cultural”	people with disabilities are seen in society. If they are poor, people see them as a liability instead. Their worth drops since no one see what they can contribute to the community”	turn makes people treat them badly. They are so rude and sometimes it's because of how they feel about themselves, they feel bad about themselves and treat people badly because of how they feel about themselves” “Like in some cases, people are just being immature or childish. In the case of children, they think that disability is a communicable disease, so they run away from people with disabilities and would not want to do anything with them” “People who do not accept people with disabilities have not understood the causes of it, how the people with disabilities should be related with, and many other things about disability. So, they feel irritated interacting with them in any way”

Box 13: Forces that promote acceptance and inclusion of people with disabilities (source: transcripts from FGD with male and female family members of people with disabilities in Ankpa and Kabba LGAs)

4.2.2.2. Community actors and stakeholders

Three FGDs were held with community actors and stakeholders in Ankpa (1 male and 1 female group) and Kabba (1 male group) LGA. These respondents live within the same localities as the people with disabilities interviewed earlier. The sections below contain feedback from the proceedings.

Stigmatisation of people with disabilities

We began by asking the respondents if people with disabilities in their communities are stigmatised, seen or labelled differently from those without disabilities and, if yes, the reasons for this behaviour. The respondents all confirmed that people with disabilities are stigmatised variously by family members and members of the community. As shown in **Box 14**, there was a near consensus that stigmatisation originates from within the families of disabled people and then transcends into society. People with disabilities are often despised and looked upon with irritation, family members don't dine with them for fear of contracting the disability, and some are starved of food and water to ensure they don't excrete on themselves.

Outside the family setting, in the community, the stigmatisation deepens. According to the respondents, people with disabilities are typically not considered to be responsible members of society, as it is believed they have little or nothing to contribute. People refuse to eat in restaurants managed by people with disabilities; those with Down syndrome are labelled as evil spirits; even those who demonstrate exceptional talents and skills in crafts and weaving are accused of getting their skill from the underworld. Disabled people are also labelled and called by the name of the disability they have. Many do not also allow their wards to be married to anyone with any form of disability unless the people with disabilities are wealthy. Due to the attendant effects of stigma, many people with disabilities develop an inferiority complex and are often found in meetings and public events seating secluded from others.

It was also ascertained that the level of stigmatisation depends on when the disability occurred. If the person with disabilities was born with it, then it is deemed to be 'spiritual'; if it occurred later in life, then it is attributed to the sins of the person or that of his family and relatives. All forms of traditional and spiritual undertones that drive stigmatisation of people with disabilities, including the belief that disabled people are cursed by the 'gods', are propagated by age-long customs through the activities of native doctors in the communities.

Male family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"Yes, they do face. For example, if people with disabilities are coming around, one will be looking at them as if they are irritating because this perception comes from the mind. The key actors here could be from the home (family members) or community" "Yes, people with disabilities face stigmatisation because we have different professionals e.g., medical doctors, native doctors. The latter, look at them with the mind that disabilities are contagious. They disassociate with them because of the perception they have against people with disabilities" "Yes, people with disabilities go through stigmatisation. For example, in the aspect of dining together with people with disabilities, some family members and community members have the feeling that they too can contract the disability of the people with disabilities if they dine with them"	"People with disabilities are not considered as responsible persons in the society because most people (non-disabled) see them as liability and have nothing to contribute to the community" "People see them incapable to do the most needful task and rely on others to do those tasks for them. The people with disabilities are also called "ogbange" (evil spirits from the underworld) whereas it's just Down syndrome. These categories of impairment are always told that they do not belong to this world. They often get neglected, exploited and most times abused" "Exceptional people with disabilities have special skills to do certain crafts. An example was of a cripple from birth who can weave mats beautifully was accused of having his ability from another realm"	"People with disabilities face stigma in the community. People look down on them, and that has made them feel like they do not belong there. For example, in an association where you have like 20 people and two of them are disabled, the ones with a disability will usually not want to sit among the others, they would separate themselves and go and sit in a secluded place. They already have low self-esteem because of how low the community places them" "Children don't like people with disabilities at all. You will see them running away from people with disabilities. Even kids that are not yet wise, if they see a physically challenged person, they glare at them and if the person comes close to them, they try to run or crawl away so that the person doesn't catch up with them. When you now go to their school, you see how children run away from children that have a disability, calling them names and not playing with them"
"People with disabilities are being starved (denied food and water). The perception here is that if you feed a person with a disability, he/she will defecate and urinate on his body. I treated a disabled person whose	"The level of stigmatisation depends on the nature of the disability, giving the instance that if it is from birth, it's spiritual and if it is at a later stage in life, it is because of one's sin or sin of their relatives. This mindset	"As far as this community is concerned, I have noticed that people name people with disabilities after the disability that they're having. And mostly in Yoruba language, they use the term or name of the disability to

family members while leaving home by 7:30 am for work, will refuse their disabled father food and water, so that he doesn't defecate and urinate on his body while they are away, thereby spoiling his clothes" "Stigmatisation starts from the home and translates to the community. Some family members will conclude that their brother or sister who is with a disability was caused by the gods. This is a very bad notion" "Talking about the sources of stigmatisation, we have the home (family), school, markets, hospitals, places of worship etc. For example, a trader feels he can contract hearing impairment if she should sell items to people with disabilities with a hearing impairment"	resulted from long time traditions when people were less exposed and not educated which was told to them by traditional priests (traditional worship) in which they believe them" "People have refused to eat in restaurants that are owned or managed by disabled persons due to resentment, believing they are not clean enough to cook or their diseases can be contagious"	call those people with disabilities. Names like "afoju" for someone that is blind" "Even when it comes to marriage, a lot of families will not allow their daughter to marry someone with a disability or vice versa. The only instance you will see that happen is when the disabled man is wealthy, or his family is wealthy. Otherwise, most families would not allow their children to marry someone who is disabled" "Sometimes even in their families, people with disabilities are being stigmatised. I saw a little girl who is physically challenged in a house I visited, the family left the little girl on the floor in a messy environment, but the other kids were playing around and everybody was doing their thing in the house. But no one even cared about the girl or what she was doing"

Box 14: Stigmatisation of people with disabilities (source: transcripts from FGD with male and female community actors in Ankpa and Kabba LGAs)

Discrimination of people with disabilities

The respondents were then asked if people with disabilities are discriminated against (treated differently) in addition to stigmatisation. Insights from the responses received (see **Box 15**) affirms that people with disabilities are denied their rights and dues just because of their disability.

According to the respondents, there is systemic discrimination against people with disabilities in all sectors of society. Regardless of their qualifications, many private and public sector employers won't employ people with disabilities. Members of society are not likely to vote for people with disabilities if they contest for elections. Health care workers prefer to attend to those without disability; those with leprosy are discarded to leprosy centres and excommunicated from society; their seats are intentionally kept at public events so that they are far away from other people; their opinions are disregarded at community meetings; they are denied of marriage, and so on. At home, family members abandon them out of tiredness and fear, which in turn exposes them to danger and harm, including rape, especially for those who can't talk.

Male family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"Generally speaking, the society is discriminating against people with disabilities. The banking sector will refuse to employ a person who is physically challenged no matter how qualified the people with disabilities is. Public organisations will not employ a person with a disability, electorates will not vote for a visually impaired or physically challenged"	"Discrimination always come about when the people with disabilities are deprived of what they are entitled to. For instance, when a physically challenged person completes his/her studies, job opportunities are kept away from them and even when given, they do not get their full entitlements. This is because it is often seen as a privilege rendered to the people with disabilities rather than deserving it" "Other forms of discrimination involve not allowing them to contribute to key decisions in the community. The reason as claimed is that they are impaired and do not have an idea of the reality in the community"	"I will say it is a 50-50 experience. Some people discriminate against them, some others discriminate for their sake. Some people give them special attention and care, while others disregard them" "They face a lot of discrimination in my own opinion. For example, employers don't like to employ people with disabilities. Some will say, the office has multiple floors, it'll be difficult for people with disabilities to climb upstairs, or a visually impaired person cannot be a doctor. Sometimes, even if people with disabilities can do what the employer says he/she cannot do, they'll still not employ them"

“When you talk of discrimination, it is known everywhere. From perception to action. Both in the military and the paramilitary, people with disabilities are not employed. In the hospitals, medical personnel will prefer to attend to fifteen (15) non-disabled persons than to attend to one disabled person because they believe that their problem is spiritually inclined” “In most cases, people with leprosy are physically challenged, there are certain people in this country that finds a secluded (excluded) place to drop people with leprosy there, to live their lives. In other words, they have been excommunicated with their families and the whole community where they come from” “In sports, we have Paralympics where people with disabilities goes to compete with their fellows. There is no able person who will want to compete with any people with disabilities in the field or tracks. People with disabilities can only compete within themselves while non-disabled persons do the same. This brings about social class and throws people with disabilities into an inferiority complex. For example, an instructor began to invite people with disabilities to his team for trainings, with time he began to lose his abled-bodied trainees as a result of the people with disabilities,	“Sometimes these people with disabilities are deprived of marriages saying that they don’t have the full physical ability to cater for a family though most times, it is purely out of resentment” “During gatherings, they are not given good reception or are given seats away from others on grounds that they will become a distraction. This has hurt the feelings of these people with disabilities several times and they tend to avoid such events as much as they can. These acts have made the people with disabilities feel rejected in their communities”	“It's the same thing with marriage. People, especially parents will stop their children from marrying people with disabilities just because of their disability. Even if they are working, so long as that person has a disability, the parents will not agree no matter what” “People take advantage of people with disabilities because of their conditions. I know a girl who was consistently being raped, but she couldn't talk, she couldn't hear, and she couldn't walk. The young man would come in the daytime when everyone had left the house, rape her and go but she couldn't talk, she also couldn't fight back. He was caught in the act one day and was taken to the police station, that was how he confessed that he had been taking advantage of the girl for a long time. So, people cheat people with disabilities because of their status or condition” “Truth be told, health workers can be so mean to people with disabilities. Some of them just treat them anyhow as they like, so when they find health workers that are kind to them, they tend to become attached to those people. Health workers are supposed to be the encouragement to these people, but you find them insulting them, yelling at

quickly he had to go back to his notice board and reschedule all the sessions to accommodate people with disabilities separately from the non-disabled persons” “The family is another source of discrimination where family members desert their brothers and sisters because they have one form of disability, as such, family members do run away and abandon their relatives who are disabled. The cause of this is that they are tired of taking care of the people with disabilities while others feel they are not supposed to identify with people with disabilities in their families. In summary, people with disabilities suffer the discrimination of rejection” “Beliefs bring about discrimination. The pregnant woman would not want to see (sight) people with disabilities so that they will not give birth to someone with a disability. On the road, when they meet people with disabilities, a Christian woman while closing her eyes will shout ‘Jesus’ and the Muslim will shout ‘Sububallahi’ and go into an emergency prayer”		them and just being unnecessarily mean to them” “I work as a health worker, and sometimes these people with disabilities really have bad attitudes and even if you want to pamper them and treat them with special care, they become so rude to you. There was a person with disabilities that came to the ward I work in, instead of her going to the antenatal ward. I described the antenatal ward for her and she didn't understand, then I held her hand intending to lead her to the ward, but she just pulled off her hands aggressively, I just gave her back her card and allowed her to go wherever she wanted to go since she didn't want my help”

Box 15: Discrimination against people with disabilities (source: transcripts from FGD with male and female community actors in Ankpa and Kabba LGAs)

The last comment from a health worker is an example of how the attitudes of heath staff reflect negatively and inappropriately on patients like taking a hold of a person’s hand without first talking to them. The health workers believe they are being helpful to the persons with disabilities, but they may be exhibiting a culture of pity and insensitivity totally.

Forces that promote acceptance and inclusion of people with disabilities

Feedback was also attained from the community actors and stakeholders on the forces that drive or support total acceptance, and support and inclusion for disabled persons in their households and community (see **Box 16** for precise responses).

In summary, the respondents identified religion as a major force that strives to reinforce that people with disabilities are also of God. Other factors include education and knowledge, as many enlightened persons neither believe that people with disabilities are evil/cursed by 'gods', nor that disability is contagious. Humanity, inherent compassion and love among certain individuals, especially women and mothers, were also mentioned as a factor. Exceptional talent and skill exhibited by people with disabilities also contribute to raising their self-worth and acceptance into society.

Male family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
"I think religion is a major force and how we are created in the image and likeness of God so that we don't look at people with disabilities with disability eye rather, look at them as God's image. This force will drive you to accept and support people with disabilities in our households and communities. Religious teachings help to shape the thinking of people"	"People are beginning to get enlightened that the disability of people with disabilities from birth is as a result of deformity which can be proven medically and has nothing to do with spirituality, while religious-wise, they are another form of God's creation. This understanding came about by reasons that people had the opportunity to be educated while others got exposed as they co-relate with other cultures and traditions since they find same people with disabilities but with a different interpretation of root causes"	"One of the things that make people accept people with disabilities or support them is having human feelings. Some people are so passionate about humanity that they feel so much compassion when they see people with disabilities. These people will take people with disabilities as their own family, and just care for them. It's just a human factor. When I see people with disabilities, I see people that have a need, and I try to help them in any way, either support them to cross the road or in any way"
"Because they are human beings like me and with the knowledge, I have, that it is not contagious, I get close to them and relate with them. I engage them in some exercise. You see, giving people with disabilities a sense of belonging is a good force that makes them feel accepted, care and affection is key"	"The discovery of unique potential from these people with disabilities amused many and has started changing the impression that they are worthless in their society contrary to former narratives that they are just a liability as well as nuisance"	"Religion plays a big role here. I usually have that compassion towards people with disabilities but Christianity admonishes us to accept everyone as equals, not feeling highly than others, including people with disabilities because God made all of us. Our culture generally does not forbid people with disabilities from
"Some professionals get close to them because of their understanding of people	"Religious leaders have also played a major part of their	

with disabilities situation that it is not a helpless situation”	acceptance since they often preach that these people are born for a purpose and making instances from their scriptures”	doing anything at all, and it does not banish them from the community at all”
“Personally, I look at them as human beings and it is not in their making to be in the condition, they found themselves. Some of the people with disabilities want to be like us, in times sport, so, I teach them sport because they love it” “The force behind women supporting people with disabilities lies in the fact that they are mothers. Mothers are compassionate and will not want to see their children suffering. They have passion for people with disabilities, and they don’t want to see them suffering at any point in time. There is this soft part of womanhood that allows women to easily be moved by the happenings around them. Again, I think women have a better understanding of what it means to love. Love has to do with caring and being affectionate at all times. In the car, when you meet a person with a disability wanting to come down, a woman will easily extend a hand of support to the people with disabilities to step down, even hold his/her belongings if they are going in the same direction. In the market, women buy meals for them, these are some little actions you put to show that you are caring”		

“From the woman's point of view, the condition can make them give birth to a physically challenged person. An adage says “monkey no fine, but him mama like am”, so with this in mind, even if a woman gives birth to a cripple, she will still love the baby as if it were to be an able child. The spirit of exhibiting true love lies in the woman” “From the religious angle, God created us equally, he instructed us to treat one another with love irrespective of your state of being. Religion does not allow us to look at people with disabilities as second-class people, because it teaches us that we are one before God. So, religion is a very strong force that enables us to accept and support people with disabilities” “The spirit of encouragement is another key force. When we organise campaigns and seminars for people with disabilities and decide to use people with disabilities as facilitators to encourage themselves, the force behind this cannot be estimated. It is said, experience is the best teacher, so, when a disabled person, talks to his fellow disabled person, the message goes deep into the listener. Again, understanding the nature of people with disabilities is important. For example, no disabled man wants you to do something for him out of self-pity, an attempt in such		

direction takes them off balance. Understanding their likes and dislike is also another strong force that helps us to support them”		

Box 16: Forces that promote acceptance and inclusion of people with disabilities (source: transcripts from FGD with male and female community actors in Ankpa and Kabba LGAs)

Forces against the acceptance and inclusion of people with disabilities

The respondents were asked to describe the forces that promote the rejection and exclusion of disabled people in their community. In summary, the issues highlighted (see **Box 17** for quotes) include inferiority complex on the part of people with disabilities (driven by their inadequate education and socialisation); belligerent behaviour (such as refusing help from others) from some people with disabilities; a blend of cultural, traditional and religious beliefs that encourage stigmatisation and discrimination; poor attitude of individuals and families, including perceptions that people with disabilities are at best liabilities; government inability to assist people with disabilities appropriately, including sensitising communities to promote the inclusion of people with disabilities, and implementing the rights of disabled people as enshrined in the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018; and compulsory sheltering of people with disabilities (like leprosy) far away from community residential areas.

Male family members of people with disabilities – Ankpa	Male family members of people with disabilities – Kabba	Female family members of people with disabilities – Kabba
“Inferiority complex from people with disabilities is a resisting force. Inferiority complex could mean, not being exposed to the four walls of the school to acquire education, not adequately sound on social life, that is the need to freely relate with people” “As a result of the inferiority complex, some people with disabilities don’t want to be assisted in doing things. For example, some people with disabilities don’t welcome people cooking for them, washing clothes or plates for	“Lack of proper orientation from the government and refusal to engage volunteers to sensitise the public on reasons to accept the people with disabilities has been a major challenge. Unfavourable policies by the government to assist these people with disabilities is seriously a major setback. Also, since the people with disabilities are humans, the human rights act should include them”	“In my hometown, there's a place where people with leprosy are taken to live. They're not allowed to live in the village. They began to grow in number because they were marrying themselves and they now have a clan. They're known as people with leprosy and referred to as unclean, so they're not allowed to live in the land with others. Also, sometimes the way the person comes into the family. For instance, if the people with disabilities were born out of wedlock, the tendencies

them, going to the market bathing them etc”		that they'll be mistreated are very high”
“So, when an able person remembers the personality of the people with disabilities, it pushes him away from helping them because he/she knows he/she will not be welcomed by the people with disabilities” “Beliefs emanating from diverse cultures is another strong force that brings about total resistance for disabled persons in our households and community. In a situation where certain cultures believe that when you relate with people with disabilities, such disability is contagious. For example, when you associate with a visually impaired, it is believed that you will also become visually impaired. So, as a result of cultural beliefs, people with disabilities are excluded from non-disable persons. They are even taken out of the community to live the rest of their lives there. Another thing is some people think that it is spiritual and they don’t want to be associated with such spirit” “Some families teach their children not to associate with people with disabilities, else they will become disabled for the rest of their lives. Such teaching turns out to become a generational lifestyle. This type of teaching children receive is also a strong force resisting the total acceptance of people with disabilities”	“People are still finding it hard to accept the people with disabilities into the society because they feel they don’t belong in these communities due to long time indoctrination from generations long ago. People still fail to see the potential (when supported) in these people with disabilities. Some of them (people with disabilities) go the extra mile to compete with the non-disabled and often succeed. The perception that these people with disabilities are both a liability and nuisance to the communities since most times they become a burden to the non-impaired, not allowing them to carry on with their lives and resort to begging to make ends meet” “Religious intolerance – some religions and societies don’t recommend street begging as a form to make ends meet, so therefore, when an impaired person is seen even if not begging, people quickly tag him/her as a beggar and that will trigger a form of resentment from these people who hate street begging” “These people with disabilities also have low self-esteem making them relegated to the background. And so, most people do not believe they have any ability even in their disability”	“There are beliefs that children that are born with a disability are not ordinary. Sometimes they say that the children are snakes, or maybe an evil spirit entered the woman's belly and removed the real child and the evil spirit remained in the womb and was given birth to. This singular belief makes a lot of people not to accept people with disabilities generally in the community” “People in the society think that people with disabilities are a burden to them. Having to care for them, or having to do things for them that they would have otherwise done by themselves, it's a huge burden on people. They are struggling, people are also struggling to help them. Also, about dwarfs, there's a belief that if a woman is pregnant for her husband and also has a sexual affair with another man, she'll give birth to a dwarf/imbecile. So, some people don't accept dwarfs around them because they believe that they are products of promiscuity” “There's also this belief that a pregnant woman should not walk around at midday, between 12noon to 3pm or at midnight because that is when evil spirits are walking around, they can kick out the child and the evil spirit remains unless she's carrying a stone or any sharp object on her body, it'll hinder

"The females among people with disabilities are shy of going into a relationship with the male non-disabled counterpart. They don't relate with one another in such a way that it will lead to marriage. In most cases what you see is disabled persons getting married to themselves. The needed integration is not there, this creates a big gap between the disabled and non-disabled. Some believe that if a non-disabled person marries a disabled person, they will give birth to disable child"		the evil spirit from entering the belly"

Box 17: Forces against the acceptance and inclusion of people with disabilities (source: transcripts from FGD with male and female community actors in Ankpa and Kabba LGAs)

4.2.3. Discussion – Force field analysis towards better inclusion of people with disabilities

Putting together the feedback from the family members of disabled people and community stakeholders, the forces that promote and restrain the acceptance, support and inclusion for disabled people in their households and community were identified. The respondents were also asked to score each force based on perceived strength or weakness, and the scoring is summarised in **Figure 11.**

As shown in **Figure 11**, the driving forces towards the expected change are described briefly below:

1. **Religion and faith** – driven by the activities of some clerics who continue to preach and remind their followers of their religious obligation to love one another and accept everyone as God's children.
2. **Education, talent and skills exhibited by some people with disabilities** – unique skills and talent displayed by some people with disabilities, including arts and crafts, in most cases endears them to the community and dispels the belief that they are liabilities.
3. **Wealth status of people with disabilities** – like above, people with disabilities who are wealthy or hail from rich families are typically not discriminated against. They are welcomed by many, participate in many community activities and are often able to marry people without disabilities.
4. **Personal experience of having people with disabilities within one's family** – in most cases, this circumstance promotes empathy and helps to

change the orientation of the family members and close relatives in terms of stigmatisation and discrimination of people with disabilities.

5. **Societal level of education and knowledge** – the higher the level of enlightenment among members of the society, the less stigmatisation and discrimination against people with disabilities. With higher education and knowledge, the predominance of negative cultural, traditional, religious or spiritual beliefs becomes less prominent.
6. **Humanity** – individuals' inherent compassion and love promote the acceptance of people with disabilities, both in families and in the wider communities.

Forces for change	Score
Humanity – individuals' inherent compassion and love	4.38
Religion and faith	4.26
Wealth status of people with disabilities	4.16
Education, talent and skills exhibited by some people with disabilities	4.14
Personal experience of having people with disabilities within one's family	3.88
Societal level of education and knowledge	3.58
Total	**24.4**

Change proposal
Total acceptance and support for people with disabilities in households and communities

Forces against change	Score
Poverty among people with disabilities	4.00
Government failures	3.78
Communication difficulty with people with disabilities	3.74
Cultural and traditional beliefs	3.72
Personal traits and appearance of people with disabilities	3.70
Inferiority complex among people with disabilities	3.52
Alienation of some people with disabilities	3.52
Poor attitude, temperament of non-disabled persons	3.50
Hostile behaviour of some people with disabilities	3.50
Genuine ignorance of causes of disability	2.80
Spiritual and religious beliefs	2.68
Total	**38.5**

Figure 11: Force field analysis of factors for and against change. Template sourced from MindTools [21]

Similarly, each of the major forces restraining the total acceptance and support for people with disabilities in households and communities is briefly described below:

1. **Communication difficulty with people with disabilities** – inability to establish and maintain communications with people with disabilities, especially deaf people, helps to fuel stigmatisation and discrimination. Many people (including some deaf persons) don't understand sign language. Sign language interpreters are themselves not always available. Also, other people with disabilities are at times irritable and prefer to remain alone.
2. **Cultural and traditional beliefs** – due to the agelong activities of native doctors, there is an entrenched belief that disability is a punishment from the 'gods' resulting from the sin of the people with disabilities (where the disability came after birth) or the sin of parents and relatives of people with disabilities (where the disability is congenital).
3. **Spiritual and religious beliefs** – similar to cultural and traditional beliefs, spiritualists and some religious leaders have advanced the belief that disabled people are cursed, capable of harm and should be avoided.
4. **Inadequate humanity/empathy** – low levels of individual compassion and love typically works against social cohesion and social capital in general, including the promotion of stigmatisation and discrimination of people with disabilities.
5. **Genuine ignorance of causes of disability** – ignorance of the causes of disability (not linked to belief in culture, tradition, religion or spirituality propositions) is also a factor.
6. **Personal traits and appearance of people with disabilities** – some people with disabilities are poorly dressed and appear unkempt. This naturally drives them away from people and invariably leads to their being stigmatised and discriminated against.
7. **Poverty among people with disabilities** – many people with disabilities are poor and unable to cater for their livelihoods. Many have resorted to begging and asking for alms for survival. This further fuels the narrative that many people with disabilities are liabilities and promotes their exclusion from the fabric of society.
8. **Inferiority complex among people with disabilities** – due to their disability and the impact of stigma and discrimination, many people with disabilities have developed an inferiority complex and prefer to isolate and exclude themselves from others and from community activities, respectively.
9. **Hostile behaviour of some people with disabilities** – some people with disabilities are at times hostile and aggressive, and even refuse help from others.
10. **Government failures** – government inability to assist people with disabilities appropriately, including sensitising communities to promote the inclusion of people with disabilities, implementing the rights of people with disabilities as enshrined in the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018, and so on.
11. **Alienation of some people with disabilities (leprosy)** – isolation of people with disabilities (such as those with leprosy) to locations far removed from community residences promotes stigmatisation and discrimination.

Looking at the scoring of each of these forces by the FGD discussants (family members of people with disabilities and community actors), the top three forces driving the acceptance and support for people with disabilities in households and communities are humanity – individuals' inherent compassion and love (4.38); religion and faith (4.26); and wealth status of people with disabilities (4.16). Likewise, the top five restraining forces are poverty among people with disabilities (4.00); government failures (3.78); communication difficulty with people with disabilities (3.74); cultural and traditional beliefs (3.72); and people with disabilities' personal traits and appearance (3.70). While the forces against change totalled at 38.5, the sum of forces for change is 24.4. As mentioned earlier, to achieve the expected change forces restraining change must be weakened and reduced, and the forces for change amplified and strengthened. Specific interventions in this regard are proposed in Section 5.2.

The force field analysis FFA tool is qualitative, and scoring is not scientific. Some of the domains identified may not be addressed by an eye care program. Specific interventions may be necessary to address them.

4.3 Key interest area 3

Findings on attitudes and behaviours of health facility staff towards people with disabilities, reflecting on their health outcomes, are presented and discussed here. Sub-sections include respondent demography, perception of health care workers and challenges.

4.3.1 Respondent demographics

Data from **Figure 12** shows that 32 health workers were interviewed, comprising 53.1% (17) females and 46.9% (15) males. More (28.1%, 9) female health workers were interviewed in Kabba LGA. Looking at the age categories, only 25% (8) of the health workers engaged in the study are youths (age <=35 years). The mean age of the respondent health workers is 44 (with a standard deviation of 11.19); the minimum and maximum ages are 20 and 59, respectively.

The categories of health care workers interviewed can be seen in **Figure 13**. 40.6% (13) of the health workers are nurses, 21.9% (7) are support staff (including cleaners, guards, drivers), while 18.8% (6) are medical records officers. 9.4% (3) classified under 'others' comprises an x-ray technician, dental technologist and a hospital secretary. The rest of the health workers interviewed include one pharmacist, one laboratory scientist and one medical doctor.

Study aimed to interview staff directly working in eye health but also others that may come in contact with persons with disabilities.

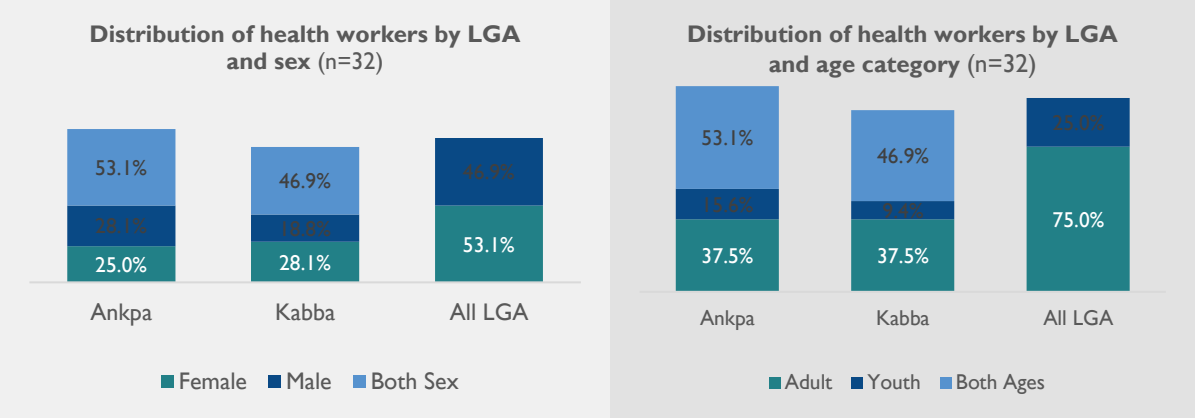

Figure 12: Distribution of health workers by LGA, sex and age category

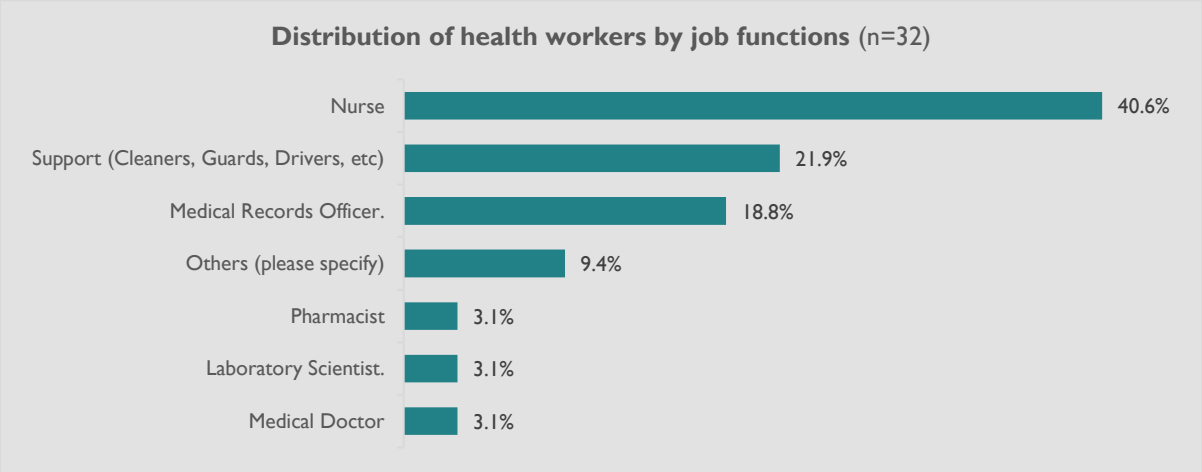

Figure 13: Distribution of health workers by job functions

Table 5: Frequency of interaction between health care workers and people with disabilities

Category of health workers	Count	Frequency of interaction with people with disabilities					
		Once a week	Once in 2 weeks	Once a month	Once in 2 months	Once in 3 months or more	No interaction
Nurses	13	46%		8%	23%	23%	
Support staff (cleaners, guards, drivers etc)	7	43%	14%	14%			29%
Medical records officers	6	50%				16.7%	33.3%
Others (x-ray technician, dental technologist, hospital secretary)	3			33.3%	33.3%		33.3%
Pharmacist	1		100%				
Medical doctor	1	100%					
Laboratory scientist	1			100%			

The regularity of interaction between the health care workers and people with disabilities was also investigated. Data from **Table 5** shows that all the health care workers interviewed had a frequent engagement with people with disabilities, with many of them meeting people with disabilities at least once a week. This indicates that they are well positioned to contribute to the study and provide informed feedback to the questions asked.

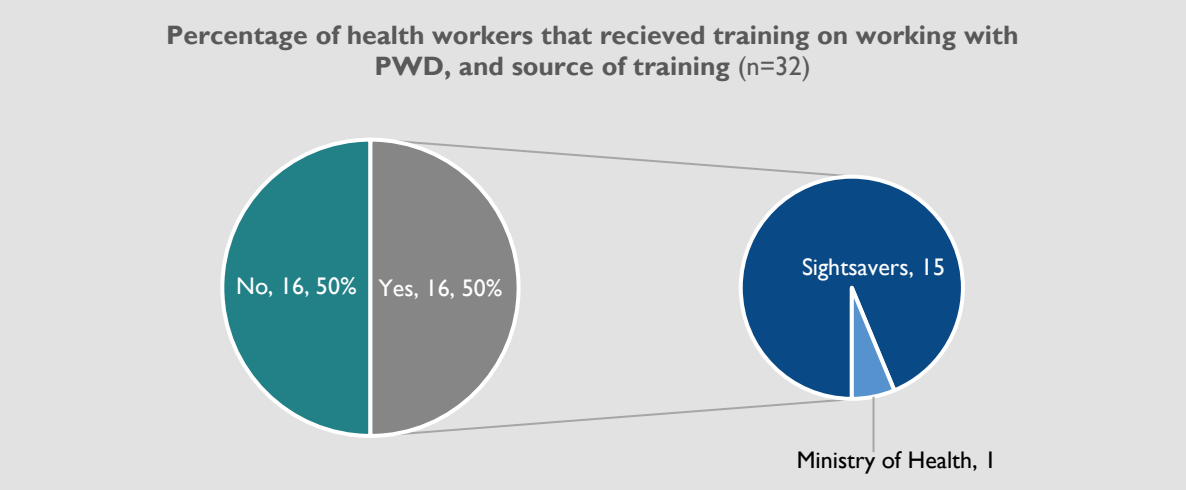

Figure 14: Frequency distribution of respondents by providing treatment to any people with disabilities

The health care workers were also asked to indicate if they have received any training (aside from their medical school training) on working with people with disabilities. 50% (16) confirmed that they have been trained in providing care and support to people with disabilities, while the other half mentioned that they haven't been trained. For those trained, all except one person stated that the training came from Sightsavers ***(Figure 14)***.

The other half of the health workforce will receive a training in the second year of the project.

4.3.2 Attitude of health workers towards people with disabilities

The study investigated the attitude of health care workers towards people with disabilities. As described earlier in **Section 3.6**, the mean for the responses for each belief statement was calculated, categorised into disagree (mean <2.50), neutral (mean ≥2.50 and <3.50), and agree (mean ≥3.50), and ranked (biggest mean score as 1st).

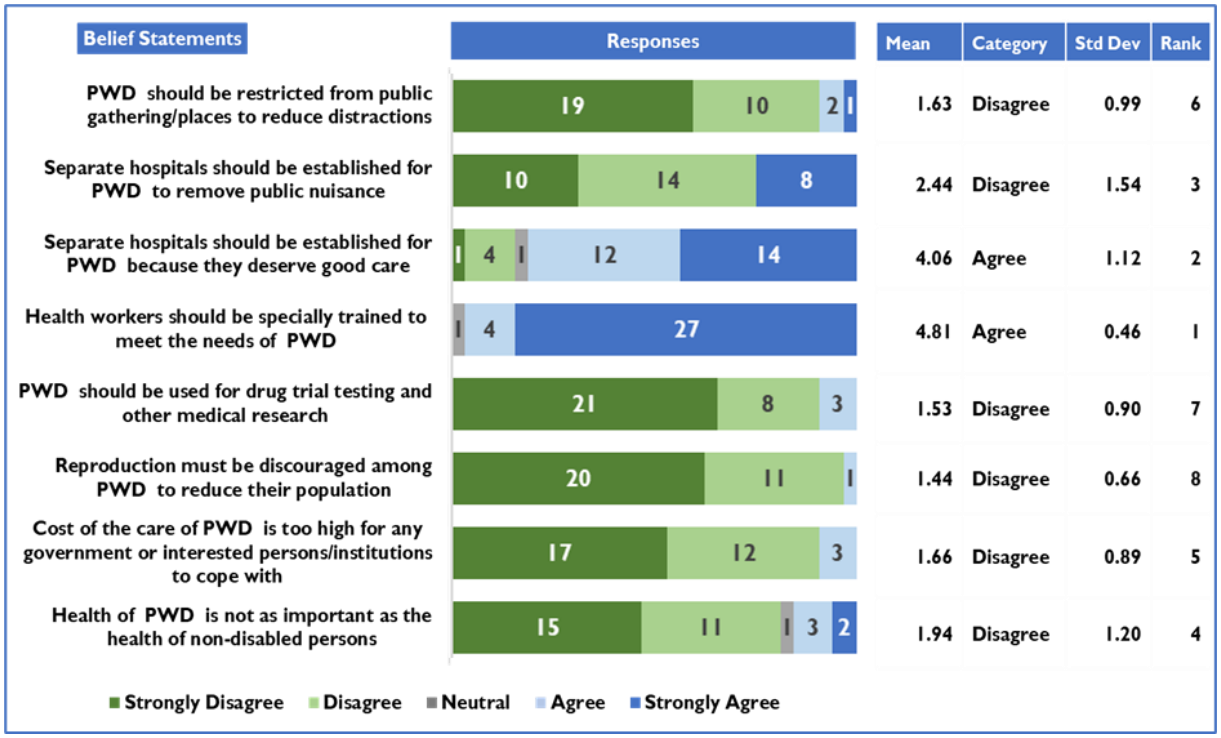

Figure 15: Attitude and beliefs of health care workers towards people with disabilities

Data in **Figure 15** shows that the health care workers disagreed with the following statements: health of people with disabilities is not as important as the health of people without disabilities (mean – 1.94/5), cost of the care of people with disabilities is too high for any government or interested persons/institutions to cope with (mean – 1.66/5), reproduction must be discouraged among people with disabilities to reduce their population (mean – 1.44/5), people with disabilities should be used for drug trial testing and other medical research (mean – 1.53/5), separate hospitals should be established for people with disabilities to remove public nuisance (mean – 2.44/5), people with disabilities should be restricted from public gathering/places to reduce distractions (mean – 1.63/5). They did agree that health workers should be specially trained to meet the needs of people with disabilities (mean – 4.81/5) and that separate hospitals should be established for people with disabilities because they deserve good care (mean – 4.06/5).

Nothing that 50% (16) of the health care workers have not received any training on working with people with disabilities, the responses were disaggregated to check if training had any effect on health workers' attitudes and perceptions towards people with disabilities. Evidence from **Table 6** shows that the responses from both trained and untrained health care workers were largely the same, except for the question of if separate hospitals should be established for people with disabilities to remove public nuisance where those trained disagreed and those untrained were undecided.

Table 6: Attitude and beliefs of health care workers towards people with disabilities categorised by training

Belief statements	Health workers already trained on working with people with disabilities			Health workers yet to receive any training on working with people with disabilities		
	Mean	SD	Category	Mean	SD	Category
The health of people with disabilities is not as important as the health of people without disabilities	2.19	1.29	Disagree	1.69	1.04	Disagree
The cost of the care of people with disabilities is too high for any government or interested persons/institutions to cope with	1.88	0.93	Disagree	1.44	0.79	Disagree
Reproduction must be discouraged among people with disabilities to reduce their population	1.44	0.79	Disagree	1.44	0.50	Disagree
People with disabilities should be used for drug trial testing and other medical research	1.56	0.79	Disagree	1.50	1.00	Disagree
Health workers should be specially trained to meet the needs of people with disabilities	4.88	0.33	Agree	4.75	0.56	Agree
Separate hospitals should be established for people with disabilities because they deserve good care	3.56	1.32	Agree	4.56	0.50	Agree
Separate hospitals should be established for people with disabilities to remove public nuisance	2.06	1.20	Disagree	2.81	1.74	Neutral
People with disabilities should be restricted from public gatherings/places to reduce distractions	1.50	0.79	Disagree	1.75	1.15	Disagree

4.3.3 Constraints that influence people with disabilities' access to eye health care services

Challenges that affect access to eye health care services by people with disabilities were also examined by asking the health workers to respond to a series of Likert scale questions. As defined in **Section 3.6**, the responses received were analysed into mean scores and classified into disagree (mean <2.50), neutral (mean ≥2.50 and <3.50), and agree (mean ≥3.50) and ranked (biggest mean score as 1st).

The perceptions of the health care workers regarding the specific constraints are shown in **Figure 16**. The respondents were undecided when asked the following questions: eye health care facilities are not easily accessible to the people with disabilities (mean – 2.66/5); special equipment required for people with disabilities are not available (mean – 3.00/5); people with disabilities' compliance to prescribed medications and treatment is low (mean – 2.75/5); families and friends of people with disabilities do not bring them to the hospitals on time (mean – 2.75/5); cost of care for people with disabilities is high, and often beyond their reach (mean – 3.03/5); it is very difficult to communicate with people with disabilities (mean – 2.94/5). However, they all agreed that they have not received enough training on how to specially care for people with disabilities (mean – 3.94/5).

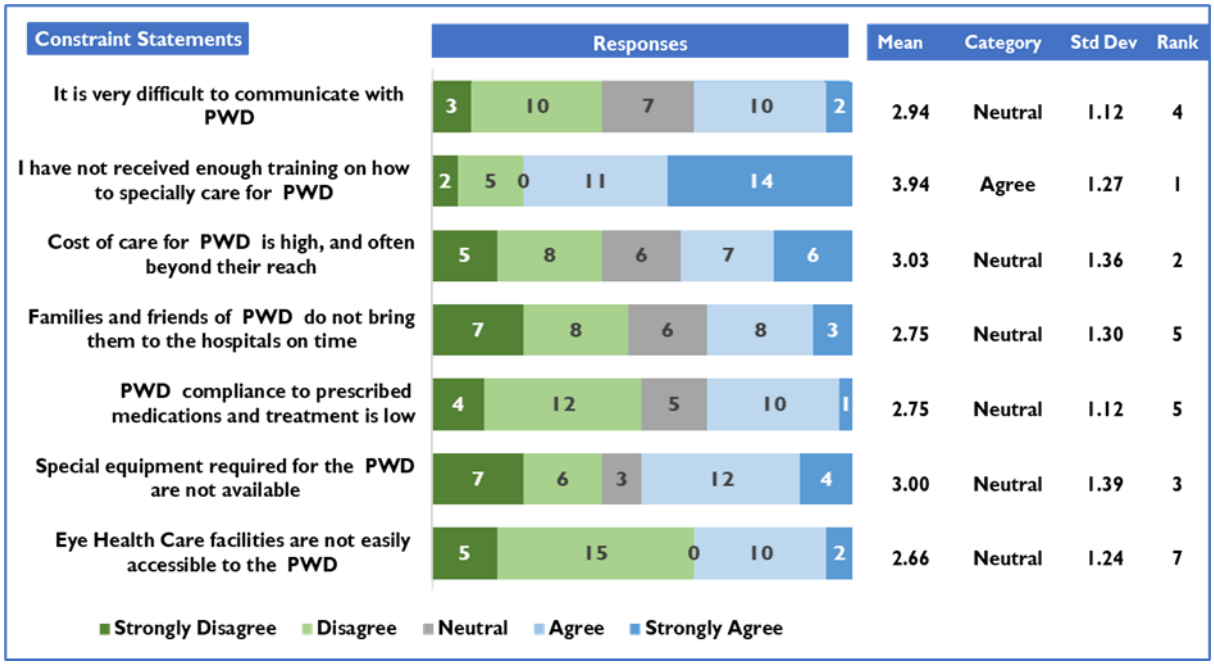

Figure 16: Health workers' perception of constraints influencing people with disabilities access to eye health care services

4.3.4. Discussion – Attitude of health care workers towards people with disabilities reflecting on their health outcomes

Results from the study showed that many of the health workers, including those yet to be trained on working with people with disabilities, have a positive perception of people with disabilities. This differs from findings from the study conducted in 2017 on the attitude of health personnel in Calabar, and factors militating against health care services for people with disabilities in Nigeria, that established that 56.3% of the health workers have a negative attitude towards people with disabilities (see **Section 2.2** above). Since the IEH project has been ongoing for a few years now, those staff who have not received training might likely have been exposed to disability inclusion, for example, through targeted camps, engagement of OPDs, the celebration of the International Day of Persons with Disabilities, and accessibility audits and renovations within facilities. Although, during the FGDs, many of the people with disabilities opined that the attitude of health care workers is a major deterrent to their decision to go for eye health checks. Earlier, a health care worker referenced an instance where a disabled person refused her assistance *(see page 45, Box 15)* as an example of people with disabilities being difficult, without the health worker realising that her behaviour might have been the challenge. Therefore, it appears that some of the health care workers need to apply positive perceptions when supporting people with disabilities at their various service points in the hospitals. Put together, while most health workers seem to display a positive attitude, more work is needed to create a more welcoming environment, tackle negative attitudes and stereotypes, and build confidence and skills among health workers.

Although the health care workers were mostly undecided when responding to questions on specific challenges and constraints that influence people with disabilities' access to eye health care services, they did, however, give some good insights presented below.

Regarding the accessibility of eye health care facilities to people with disabilities, the respondents confirmed that the road leading to these facilities are not in a good condition, which to some extent discourages access to these centres. Another respondent mentioned that Ankpa zonal hospital is located strategically near several communities, and that the hospital was also built so that people with disabilities can move easily without obstructions. For instance, there are fewer elevations like staircases, tiles are not slippery, and restrooms and clinics are easily accessible for wheelchairs.

On the availability of specialised equipment required for people with disabilities, it was mentioned that not all equipment needed is available, including ophthalmic equipment. Again, some of the specialised equipment available are mostly assistive devices for the visually impaired (cane or walking sticks) rather than for all other types of disabilities (hearing aids for example). Another respondent confirmed that most hospitals have specialised equipment for people with disabilities, though they still need more. Sightsavers' eye clinic in Ankpa zonal hospital was cited as an

example of a well-equipped health centre with some special equipment for people with disabilities.

Concerning people with disabilities' compliance to prescribed medications and treatment, the general perspective from health workers was that, as typical with even people without disabilities, many people with disabilities comply with their drugs and treatment while others don't. For people with disabilities, low compliance to medication and treatment regimes often comes from a perception that the medications are not effective. Sometimes, people with disabilities don't have people to support them to take their medications.

Mixed feedback was also received from the health workers when asked if families and friends of people with disabilities bring them to the hospital on time. One respondent agreed that many families of people with disabilities bring them to the hospital on time because they know they deserve care and attention just like any other person. Some families bring in people with disabilities to the health facility even when the condition is not serious. Another respondent mentioned that some families delay taking people with disabilities to health facilities because they believe the problem is spiritual, so they take them to prayer houses first. Some other families refuse to take people with disabilities to the hospital completely. However, it is important to note that although many people with disabilities rely on their family members and relatives to access health care services, this should not be the norm. People with disabilities have a right to independently access health care; however, due to barriers discussed earlier (such as lack of accessible transportation and infrastructure, inadequate finance and so on), many are constrained to rely on family members and friends to help them access the services needed. This puts extra pressure on relatives and friends, who are not always able to provide support as required – and in some circumstances have negative attitudes which impact the support received by people with disabilities.

On affordability of eye health care services, some health care workers believe that the cost is generally affordable depending on one's valuation of good health. However, other respondents mentioned that the cost of eye care is beyond the reach of many people with disabilities who are either low-income earners or don't even earn at all. An example alluded to the cost of cataract-removal for one eye which is pegged at ₦70,000, and the cost for registration which is ₦500.

The health care workers unanimously agreed that they have not received enough training on how to specially care for people with disabilities. Some were only introduced to courses on working with people with disabilities during their nursing training, some attended the one-day training on people with disabilities organised by Sightsavers, while others were never trained. Many of the respondents called for more training since learning is a continuous process.

Regarding communication with people with disabilities, the health workers mentioned that they had serious problems communicating with deaf people, unlike visually impaired or physically impaired persons, since they don't understand or use sign language. They also mentioned that many deaf people themselves don't know

sign language. In a number of service points in the hospitals, sign language interpreters are not available to aid communication with people with disabilities.

Other challenges mentioned by the health workers which influence people with disabilities' access to health care include the level of stigmatisation and discrimination in communities; the inability of health care workers to devote extra care and time (due to the large number of patients waiting to receive care) in attending to people with disabilities (rather than attending to them as they would to people without disabilities); inferiority complex expressed by many people with disabilities; and inadequate finance and income flow to offset the cost of eye health care.

4.4 Communication sources and preferences

The channels and sources of information on health-related matters were also included as an aspect of the study. The purpose is to ascertain people with disabilities' choice/trusted communication sources and channels for possible adoption when the SBC interventions are implemented in future. Findings, disaggregated by disability category, are presented below.

4.4.1 Preferred communication channels

For visually impaired people, prominent channels of health-related messages mentioned include TV, the internet and radio. While their families and friends source information from both the TV and the internet on their behalf, many visually impaired people listen to the radio. Each of the channels have their unique advantages: the TV provides more details and clear messages because of its visuals, the radio is more affordable, and the internet has the most diverse and global content. The radio, however, is their most trusted since they can listen to it directly and it gives more verified and edited information (like the TV), unlike the internet.

For deaf people, the main sources of health-related messages mentioned include radio, television, text messages and newspapers. In terms of features, deaf people mentioned that radio is the most trusted (local languages are spoken) and affordable (since batteries are not expensive). With radio, family and friends can get a lot of good information and report to them. The TV is also important as it enables them to see what is being presented. The TV is even more valued if there is a sign language interpreter. Additionally, both the radio and TV have specific health-related programmes. Text messages are crucial because they are easy to read and more cost-effective. The newspaper is equally important because you can read about many stories and view pictures, although it is more expensive than a text message.

For physically impaired people, channels of health-related messages mentioned include TV, radio, and the internet/social media. The TV, radio and internet/social media news is not always trusted by physically impaired people because they believe it is sometimes fraught with fake news.

4.4.2 Trusted communication sources

For visually impaired people, the most trusted information sources mentioned include family and friends (including fellow visually impaired), health volunteers and NGOs, and clergy. Again, each has its unique merit and reason for that trust. Family members are trusted because they are part of the family and information from them is more frequent and handier. Health workers and volunteers are trained professionals and are believed to provide messages that are both factual and government approved. Information from the clergy is highly regarded because of the belief that they are ‘servants of God’ and hence won’t lie or mislead others.

Like visually impaired people, deaf participants cited teachers, clergy, health personnel and family members as their most trusted sources of health information. The students among the deaf people mentioned their teachers because they believe they have the requisite knowledge to guide them. The clergy were also revealed to be very important for similar reasons stated above by visually impaired participants. Deaf people were also confident in the health information given to them by their family members.

The most trusted sources used by physically impaired people include the clergy (via religious centres), community leaders (via town criers), and family because of the perceived authentic nature of messages and information received from these three sources.

4.4.3 Ownership of smartphones

None of the visually impaired participants own a smartphone. 38% of deaf people and 46% of physically challenged people affirmed that they have a smartphone.

5. Summary, proposed actions and conclusions

5.1. Summary of key insights

5.5.1 Key interest area 1 – Factors that enable or prevent people with disabilities from seeking eye health care

The factors that enable or prevent people with disabilities from seeking eye health care at a hospital and/or at the community level are summarised below. These factors were identified by triangulating the responses (on the major or crucial factors that influence their behaviour) from the various male and female people with disabilities groups and the feedback from the COM-B survey. In developing these summaries, similar themes were condensed and merged into broader themes.

Table 7: Mapping of key enablers to people with disabilities seeking eye health care

Key factors that enable people with disabilities from seeking eye health care	Visually impaired persons	Deaf persons	Physically impaired persons
1. Awareness of the importance of the eyes and the desire to regain or maintain good eyesight		To avoid multiple disability burden	To avoid multiple disability burden
2. Availability and knowledge of equipped and functional health care facilities (with trained specialists, medication and so on)		Including the availability of sign language interpreters	Including availability of wheelchair ramps, etc
3. Support, encouragement, enlightenment, and ready assistance from family, community members, health care workers, religious bodies, NGOs and institutions			
4. Availability of financial resources to facilitate transport to/from hospital and payments for registration, consultation and medication			

5. The emergence of symptoms of severe eye defect			

Note: Shaded portions indicate the category of people with disabilities each factor applies to, based on the study analysis.

Five (5) factors were determined by the study as the most important factors that enable people with disabilities from seeking eye health care (see **Table 7**). These factors are further discussed below.

Awareness of the importance of the eyes and the desire to regain or maintain good eyesight was mentioned by all categories of people with disabilities as a critical factor. This awareness and desire are reinforced by their knowledge of people they know who became blind and seeing them go through hard times, and the need to avoid stigmatisation and discrimination resulting from loss of eyesight. Deaf people and physically impaired people are additionally conscious that they are already disabled and hence must do all they can to maintain their eyesight and avoid the tragedy and burden of multiple disabilities.

Availability and knowledge of equipped and functional health care facilities also emerged as important factors. The presence of qualified specialists, including sign language interpreters for deaf people, was highlighted as a key driver. For physically impaired persons, ease of access and movement within the different sections in the hospital encourages them as well. Similarly, a well-equipped hospital pharmacy where they can purchase most of the prescribed medications, removing the time and effort needed to source for the drugs, was mentioned repeatedly by many respondents.

Another key category of enabling factors is the support, encouragement, enlightenment and ready assistance from family and community, including health care workers, religious bodies, NGOs and institutions. This factor was expressed strongly by visually impaired and physically impaired people. Where family and community members are supportive and express genuine love and care rather than show discriminatory attitudes, people with disabilities feel encouraged and willing to go for eye health checks. Similarly, counselling, encouragement and a positive attitude from health care workers further inspire people with disabilities to keep to the follow-on hospital appointments. Free and subsidised medical treatment by churches and NGOs is another driver under this factor.

Availability of financial resources or funds was determined to be a crucial enabler for all categories of disabled people. Funds are needed to facilitate transport to the hospital for an initial check-up and subsequent visits, payments for hospital registration cards and consultation fees, and the purchase of prescribed medication.

Lastly, physically impaired people mentioned that the manifestation of symptoms of severe eye defects often results in an automatic decision to visit the eye health care centres or hospitals for checks.

Table 8: Mapping of key factors that prevent people with disabilities from seeking eye health care

Key factors that prevent people with disabilities from seeking eye health care	Visually impaired persons	Deaf persons	Physically impaired persons
1. Poverty – inadequate finance to access the health care centre and support the cost of treatment and medications			Proximity to the health care facilities
2. Loss of hope and belief that there is no cure or remedy for their eye condition			
3. Fear of being stigmatised and discriminated against			
4. Poor attitude of health care workers			
5. Health care centre inadequacies (inadequate experts, sign language interpreters, accessible facilities, medications)			Inadequate structures to aid mobility
6. Ignorance of the importance of regular eye-checks			

Note: Shaded portions indicate the category of people with disabilities each factor applies to, based on the study analysis.

As shown in **Table 8,** six (6) factors were determined as the most prominent factors that prevent or limit people with disabilities from seeking eye health care.

Top on the list of barriers for all categories of people with disabilities is poverty. Due to their disability, many people with disabilities rely on handouts and cash transfers from family members and friends to survive. Often, most of them are unemployed and are unable to sustain their livelihoods. The limited fund in their possession is barely enough to cater for their basic needs and is often allocated to the purchase of food and daily sustenance items rather than to health care checks.

For visually impaired people, loss of hope and belief that there is no cure or remedy for their eye condition is a primary demotivator to seeking eye health care. This state of mind is often fuelled by discouragement from family and friends who continually ridicule any attempt they make to seek eye health care as a futile effort.

Fear of being stigmatised and discriminated against by people they meet on their trip to and within the hospital is another factor identified by visually and physically impaired persons as a key challenge and demotivator.

All categories of people with disabilities expressed displeasure with the poor attitude of some health care workers they meet. For deaf people, the experience is compounded by communication problems, especially where there are no sign language interpreters.

Inadequacies at the health care centres also emerged as a major barrier for all categories of people with disabilities. These shortfalls include inadequate experts and specialists where student health care personnel are assigned to attend to them; unavailability/limited availability of sign language interpreters to assist deaf people in communicating with health care workers; inadequate mobility aids that facilitate movement by people with disabilities within health care facilities; and limited availability of prescribed medications in the hospital pharmacies.

Finally, ignorance on the need for regular eye checks as a major barrier was highlighted by many respondents across the people with disabilities categories as a serious barrier. Many people with disabilities summon up courage and zeal to visit the eye health centres when they have severe symptoms of eye defects.

5.1.2 Key interest area 2 – Stigma and social norms that define the eye health-seeking pattern of people with disabilities

The study revealed the incidence and influence of stigma and social norms on the eye health-seeking behaviour of people with disabilities. Regarding the major origin and sources of stigma, it was established that due to the agelong activities of native doctors, there is an entrenched belief that disability is a punishment from the ‘gods’ resulting from the sin of the people with disabilities (where the disability came after birth) or the sin of parents and relatives of people with disabilities (where the disability is congenital). Similarly, spiritualists and some religious leaders have advanced the belief that disabled people are cursed, capable of harm, and should be avoided. Since their followers trust them completely, these further fuels the stigmatisation and discrimination of people with disabilities. This may also be true for persons with disabilities as shown before that they trust leaders and may self-internalise stigma. Away from the traditional and spiritual connotations, people with disabilities are also stigmatised due to the difficulty in communicating with some of them (for instance deaf people); the belief that their conditions are communicable; their social outlook and appearance (their pattern and type of dressing); and their living standards and poverty status.

Following interactions with family members of people with disabilities and community actors, the forces driving the acceptance and support for people with disabilities in households and communities are humanity – individuals’ inherent compassion and love; religion and faith; wealth status of people with disabilities; education, talent and skills exhibited by some people with disabilities; personal experience of having

people with disabilities within one's family; and societal level of education and knowledge.

Likewise, the forces restraining the acceptance and support for people with disabilities in households and communities are poverty among people with disabilities; government failures; communication difficulty with people with disabilities; cultural and traditional beliefs; personal traits and appearance of people with disabilities; inferiority complex among people with disabilities; alienation of some people with disabilities; poor attitude, temperament of people with disabilities; hostile behaviour of some people with disabilities; genuine ignorance of causes of disability; and spiritual and religious beliefs.

To achieve the desired change – total acceptance and support for people with disabilities in households and communities – interventions to amply influence the driving forces and limit the effect or influence of the restraining forces needs to be designed and implemented sustainably.

5.1.3 Key interest area 3 – Attitude of health care workers towards people with disabilities

Results from the study showed that many of the health workers have a positive perception of people with disabilities. Both trained and untrained health care workers provided correct responses to almost all the behavioural questions posed to them. The majority disagreed with the following belief statements: health of people with disabilities is not as important as the health of people without disabilities; cost of the care of people with disabilities is too high for any government or interested people/institutions to cope with; reproduction must be discouraged among people with disabilities to reduce their population; people with disabilities should be used for drug trial testing and other medical research; separate hospitals should be established for people with disabilities to remove public nuisance; people with disabilities should be restricted from public gathering/places to reduce distractions. Conversely, they agreed that health workers should be specially trained to meet the needs of people with disabilities. Some of them suggested that separate hospitals should be established for people with disabilities because they deserve good care. While the creation of separate hospitals may seem fair, it would further highlight discrimination and segregation. It must be noted, however, that while people with disabilities may require specific services (such as rehabilitation and psychosocial support) provided in specialist facilities, they also deserve equitable access to health care provided for everyone in other health care facilities. One question where a different response was obtained was on 'whether separate hospitals should be established for people with disabilities to remove public nuisance', where those trained disagreed and those untrained were undecided.

During the FGDs, many of the people with disabilities mentioned the attitude of health care workers as one of the major factors that prevent them from seeking eye health checks. This view is supported by an instance where a health care worker narrated a 'bad behaviour' from a person with a disability while oblivious of her action which triggered the reaction.

Certain challenges were expressed by the health workers which shape their interaction with people with disabilities in the hospitals. First, they mentioned that they have not received enough training on how to specially care for people with disabilities. Some of them were only introduced to courses on working with people with disabilities during their nursing training, some attended training organised by Sightsavers, while others have never trained.

The next challenge concerned communication with people with disabilities – health workers stated that they had serious problems communicating with deaf people, unlike visually impaired or physically impaired people, since they don't understand or use sign language. They also mentioned that many deaf people themselves don't know sign language. In a number of service points in the hospitals, sign language interpreters are not available to aid communication with people with disabilities.

Thirdly, the health care workers decried their inability to devote more time to people with disabilities due to understaffing of the hospitals and the multiple roles and shifts the staff endure daily.

5.2. Proposed interventions

To address the barriers summarised for each key interest area (**Section 5.1**), based on the views and interactions with the respondents, the study proposed intervention types and specific activities aimed at contributing to the expected behavioural outcomes: increased visitation to hospitals by people with disabilities for eye health care purposes; total acceptance of people with disabilities within families and communities; and improved attitude of health care workers towards people with disabilities (see **Table 9**).

For this purpose, nine (9) broad intervention types were adopted from the behaviour change wheel (see **Section 2.1.1**), some of which can be implemented in the lifetime of the project and some for longer-term advocacy to the health authorities. These intervention types include: (a) education – increasing knowledge and understanding by informing, explaining, showing and providing feedback; (b) persuasion – using words and images to change the way people feel about a behaviour to make it more or less attractive; (c) incentivisation – changing the attractiveness of a behaviour by creating the expectation of a desired outcome or avoidance of an undesired one; and (d) coercion – changing the attractiveness of a behaviour by creating the expectation of an undesired outcome or denial of a desired one [25]. Others include (e) training – increasing the skills needed for a behaviour by repeated practice and feedback; (f) restriction – constraining the performance of a behaviour by setting rules; (g) environmental restructuring – constraining or promoting behaviour by shaping the physical or social environment, (h) modelling – showing examples of the behaviour for people to imitate; (i) enablement – providing support to improve the ability to change in a variety of ways not covered by other intervention types. [25]

All the interventions are not feasible in the context of this project. the team needs to prioritise what is feasible and to support the government implement the others by way of longer-term advocacy steps.

To achieve the targeted behavioural outcome of key interest area 1 – increased visitation to hospitals by people with disabilities for eye health care purposes, the following intervention activities were suggested to address specific key barriers:

a. To address the issue of people with disabilities' inadequate finance, environmental restructuring and enablement interventions were proposed, as follows: pursue funding to introduce subsidies and organise free medical outreaches; stimulate individual and private sector CSR contributions; encourage people with disabilities to sign-up on National Health Insurance Scheme (NHIS); advocate for the inclusion of more eye drugs in NHIS and special considerations for people with disabilities; advocate to the government to allocate more funds to eye health care for people with disabilities.

b. To restore the hope and belief of the people with disabilities, the following educational and persuasion related interventions were suggested: hold enlightenment events focusing on restoring hope and benefits of caring for the eyes; design and disseminate appropriate communication materials; identify and share relevant testimonials and success stories.

c. Regarding the inadequacies in the health care centres (inadequate experts, sign language interpreters, accessible facilities, medications and so on), the following environmental restructuring and enablement interventions were proposed: engage hospital management to put in place mobility enhancement aids for people with disabilities; engage hospital management to increase specialist staff for people with disabilities, including sign language translators; advocate for improved supply of eye medications at various hospitals; stimulate individual and private sector CSR contributions.

d. To improve awareness on the importance of regular eye-checks by people with disabilities, some educational and persuasion-related intervention actions were proposed, including holding awareness creation sessions on the dangers of late detection of eye defects; and engaging traditional and religious leaders to sensitise their subjects on the need to go for regular eye checks. Other intervention activities suggested include: the provision of incentives at screening centres (incentivisation); design of flyers using pictures to show the effect of late detection of eye diseases (coercion); identification and sharing of testimonials and success stories on early detection (modelling); facilitation of free or subsidised eye health care outreaches (environmental restructuring and enablement).

Table 9: Proposed intervention types and specific actions aimed at achieving targeted behavioural outcomes of each study key interest area (KIA)

Barriers to be addressed	Key interest area, targeted outcome	Intervention types and actions							
		Education	Persuasion	Training	Incentivisation	Coercion	Modelling	Restriction	Environm restructu
Inadequate finance by people with disabilities to access the health care centre, support the cost of treatment and medications	**KIA 1:** Increased visitation to hospitals by people with disabilities for eye health care purposes								• Pursue subsidie medical • Stimula private contribu • Encoura disabilit NHIS • Advoca of more and spe for peop • Advoca governn more fu care for disabilit
People with disabilities' loss of hope	**KIA 1:** Increased visitation to	• Hold enlightenment events focusing on restoring hope and					Identify and share relevant		

Barriers to be addressed	Key interest area, targeted outcome	Intervention types and actions							
		Education	Persuasion	Training	Incentivisation	Coercion	Modelling	Restriction	Environm restructu
and belief that there is no cure or remedy for their eye condition	hospitals by people with disabilities for eye health care purposes	the benefits of caring for the eye • Design and disseminate appropriate communication materials in this regard					testimonials and success stories		
Stigmatisation and discrimination of people with disabilities	**KIA 2:** Total acceptance of people with disabilities within families and communities **KIA 1:** Increased visitation to hospitals by people with disabilities for eye	• Hold targeted awareness creation sessions for families, communities, public and private sector institutions on the causes of disability and the dangers of stigmatisation and discrimination • Engage community, traditional and religious leaders to sensitise their subjects and lead the campaign against		• Train people with disabilities on appropriate vocational skills to help them secure gainful employment opportunities. • Train the family members of people with disabilities on how to care and them			Identify and share relevant success stories on people with disabilities who are excelling and contributing to society	• Engage the government to implement the rights of disabled people as enshrined in the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018 • Engage traditional and community	• Facilitat employ and link disabilit • Advoca sector t people • Facilitat people special schools • Advoca and priv allocate special with dis

Barriers to be addressed	Key interest area, targeted outcome	Intervention types and actions							
		Education	Persuasion	Training	Incentivisation	Coercion	Modelling	Restriction	Environm restructu
	health care purposes	stigmatisation and discrimination		• Train people with disabilities on life skills to build their confidence, self-worth, interpersonal and communication skills				leaders to sanction those who discriminate against people with disabilities	• Engage (especi the com includin continu rights o disabilit
Poor attitude of health care workers	**KIA 3:** Improved attitude of health care workers towards people with disabilities **KIA 1:** Increased visitation to hospitals by people with	Hold interactive sessions with health care workers to understand their limitations, how to overcome the challenges and be more supportive		• Train health care workers on care for people with disabilities • Train health care workers on ethics and soft skills, including negotiation and communication skills	Establish a periodic award to reward compliant health care workers			• Put in place feedback boxes at various service points • Enforce hospital rules on patient care and management	

Barriers to be addressed	Key interest area, targeted outcome	Intervention types and actions							
		Education	Persuasion	Training	Incentivisation	Coercion	Modelling	Restriction	Environm restructu
	disabilities for eye health care purposes								
Health care centre inadequacies (inadequate experts, sign language interpreters, accessible facilities, medications and so on)	**KIA 1:** Increased visitation to hospitals by people with disabilities for eye health care purposes								• Engage manage mobility for peop • Engage manage speciali people includin translat • Advoca supply at vario • Stimula private contribu
Ignorance of the importance of regular eye-	**KIA 1:** Increased visitation to hospitals by	• Hold awareness creation sessions on the dangers of late			• Provide incentives at screening centres	Design flyers using pictures	Identify and share testimonials and		• Facilitat free or health c

Barriers to be addressed	Key interest area, targeted outcome	Intervention types and actions							
		Education	Persuasion	Training	Incentivisation	Coercion	Modelling	Restriction	Environm restructu
checks by people with disabilities	people with disabilities for eye health care purposes	detection of eye defects • Engage traditional and religious leaders to sensitise their subjects on the need to go for regular eye checks				to show the effect of late detection of eye diseases	success stories on early detection		

Similarly, to achieve the targeted behavioural outcome of key interest area 2 – total acceptance of people with disabilities within families and communities, the following intervention types and activities were suggested to address the issues around stigmatisation and discrimination:

a. Two (2) educational and persuasion activities suggested include: holding targeted awareness creation sessions for families, communities, public and private sector institutions on the causes of disability and the dangers of stigmatisation and discrimination; and engaging community, traditional and religious leaders to sensitise their subjects and lead the campaign against stigmatisation and discrimination.
b. Several capacity-building activities were suggested to empower people with disabilities, including training on appropriate vocational skills to help them secure gainful employment opportunities; training of the family members of people with disabilities on how to care and support them; and training of people with disabilities on life skills to build their confidence, self-worth, inter-personal and communication skills.
c. To deter those who continually discriminate against people with disabilities, restrictive intervention actions proposed include: engaging the government to implement the rights of disabled persons as enshrined in the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018; and engaging traditional and community leaders to sanction those who discriminate against people with disabilities.
d. Environmental restructuring and enablement intervention activities proposed include: facilitating the enrolment of people with disabilities into special schools; facilitating the creation of employment opportunities and linking people with disabilities to secure jobs; advocating to the private sector to employ qualified people with disabilities; advocating to government and private sector to allocate more funds to special schools for people with disabilities; engaging more NGOs (especially those working at the community level), including the OPDs, to continue to champion the rights of people with disabilities.
e. To counter the notion that people with disabilities are not useful to the community, the study proposed a modelling intervention activity – identification and sharing of relevant success stories on people with disabilities who are excelling and contributing to society.

Finally, to achieve the targeted behavioural outcome of key interest area 3 – improved attitude of health care workers towards people with disabilities, the following intervention types and activities were suggested.

a. Hold interactive sessions with health care workers to understand their limitations, how to overcome the challenges and be more supportive. This educational and persuasion-related intervention offers the opportunity to provide feedback from people with disabilities, understand the health worker's perspective and stimulate increased adoption of the proposed behaviour.
b. Core capacity building interventions suggested for health care workers include training on care for people with disabilities, and training on ethics and soft skills, including negotiation and communication skills.

c. Other intervention activities suggested include establishing a periodic award to reward compliant health care workers (incentivisation); putting in place feedback boxes at various service points; and enforcing hospital rules on patient care and management (restriction).

5.3. Conclusion and next steps

This study was designed and executed to generate insights on three areas, including understanding what enables or prevents people with disabilities from seeking eye health care at a hospital and/or at the community level; insights into stigma and social norms that define the eye health-seeking pattern of people with disabilities; and attitudes and behaviours of health facility staff towards people with disabilities reflecting on their health outcomes.

Several key findings along each key area of interest were determined, and follow-on intervention actions were suggested. We invite the Sightsavers team to review the recommended actions and determine those that can be utilised in the development of an appropriate SBC strategy, and in other advocacy work and initiatives aimed at improving access to eye care services among people with disabilities in selected communities in Kogi State.

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Annexe 1 – Details of local literature reviewed

S/n	Study title	Year of publishing	Study location	Participants	Design/method	Link
1	Determinants of health care seeking behaviour and unmet need among people with physical disabilities in Nigeria	2019	Nigeria	285 respondents: 43.7% females and 56.3% males	Cross-sectional population-based survey using multi-stage sampling methods	https://doi.org/10.32827/ijphcs.6.1.61
2	The Problems of Living with Disability in Nigeria	2017	Nigeria	Documentary sources: Library, internet and personal collections of individuals	Literature review	Microsoft Word – JLPG-Vol.65 2017 (iiste.org)
3	Barriers to Accessing Services by People with Disabilities in Nigeria: Insights from a Qualitative Study	2016	Nigeria	12 participants: 5 executives of DPOs and 7 individuals with disabilities were interviewed	Qualitative methods	https://doi.org/10.5901/jesr.2016.v6n2p113
4	The Face of Disability in Nigeria: A Disability Survey in Kogi and Niger States	2011	Kogi and Niger States	1,093 respondents: 37% vision, 32% mobility	Quantitative methods	http://doi.org/10.5463/dcid.v22i1.11

S/n	Study title	Year of publishing	Study location	Participants	Design/method	Link
				and 15% hearing		
5	Survey of disability, accessibility, and utilization of rehabilitation service, in a community of Kano State: north western Nigeria	2018	Kano State, Nigeria	86 participants	Descriptive study	http://doi.org/10.15406/ipmrj.2018.03.00146
6	Attitude of Health Personnels in Calabar and Factors Mitigating Against Health Care Services for Handicapped Persons in Nigeria	2007	Cross River State, Nigeria	265 health workers	Purposive sampling technique	(PDF) Attitude of Health Personnels in Calabar and Factors Militating Against Health Care Services for Handicapped Persons in Nigeria (researchgate.net)
7	Accessibility of People with Disabilities to Productive Resources in Nigeria: Dream or Reality?	2020	Oyo, Ekiti, Ondo and Osun States, Nigeria	300 people with disabilities	Descriptive study	Accessibility of People with Disabilities to Productive Resources in Nigeria: Dream or Reality? | Ogunjimi | Journal of Disability Studies (iscience.in)

Annexe 2 – Data collection tools and datasets

Respondent categories	Tools	Datasets
Key interest 1: Persons with disability – all categories	1. Questionnaire on demographics, COM-B model survey, disability classification Tool_1_PWD.xlsx 2. FGD question checklist Tool_1_PWD_FGD.docx	Demographics, COM-B model survey, disability classification Dataset_Tool_1_PWD.xlsx
Key interest 2: Family members of disabled persons and community actors	1. Demographics questionnaire Tool_2_Family_Community.xlsx 2. FGD and force field questionnaire Tool_2_Family_Community_FGD.docx	Demographics Dataset_Tool_2_Family_Community.xlsx
Key interest 3: Health care workers	1. Semi-structured questionnaire Tool_3_Health_Workers.xlsx	Demographics, belief statements, constraints Dataset_Tool_3_Health_Workers.xlsx

Annexe 3 – Ethical approval

Ethical approval - Kogi SBC.pdf

Annexe 4 – Consent form

Sightsavers consent form 2019.docx

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The Institute of Development Studies | International Disability Alliance
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