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"We never leave anyone behind": a qualitative study of stakeholders' perspectives on disability-inclusive maternity care in Cambodia

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Abstract

Background Despite some progress towards disability rights in Cambodia, women with disabilities still experience inequitable access to maternity care. To provide a context-specific understanding of this complex issue, we conducted a study exploring the perspectives of key stakeholders from across the health and disability sectors regarding disability-inclusive maternity care in three locations of Cambodia: Phnom Penh, Kampong Speu, and Kampot.

Methods This study employed a qualitative descriptive approach, using semi-structured interviews with twelve government and non-governmental stakeholders. Data were transcribed verbatim, translated from Khmer to English, anonymised, and thematically analysed using the WHO Quality of Care framework.

Results Alongside presenting findings relevant to (1) Perceptions and conceptualisation of disability-inclusive maternity care, results were thematically presented across the relevant WHO Quality of Care framework components, including (2) Competent and motivated human resources; (3) Essential physical resources; (4) Provision of care; (5) Experience of care. All stakeholders unanimously agreed that maternity care services for women with disabilities were not inclusive, including the absence of disability-inclusive maternity care policies, guidelines and training for the healthcare workforce. Barriers to access were exacerbated when health services lacked sufficient human resources, equipment and referral systems to accommodate the needs of this population. Government stakeholders conceptualised disability-inclusive care as equal treatment without discrimination. Some commended existing social protection funding and considered it adequate to support access to maternity care. In contrast, non-governmental stakeholders emphasised that equitable maternity care requires both accessible infrastructure and services and more effective implementation of social protection measures.

Conclusion This study provided the context of the disability-inclusive maternity care in Cambodia from the perspectives of key stakeholders. The study highlighted that the Cambodian health system was inadequately responding to the maternity care needs of women with disabilities. A collaborative approach among government

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staff and relevant stakeholders is needed to develop a disability-inclusive maternity care policy and ensure effective implementation, monitoring, and evaluation. Additionally, capacity building for healthcare providers with disability inclusion is essential to ensure that women with disabilities are not left behind when they access maternity care.

Keywords Disability-inclusive maternity care, Persons with disabilities, Maternal health services, Stakeholder participation, Health services accessibility, Healthcare policies, Cambodia

Introduction

Globally, increasing evidence highlights that women with disabilities continue to encounter barriers in their access to maternity care [1–7]. Alongside discrimination within and external to the healthcare system, women with disabilities encounter barriers within the built environment, information and communication, financial barriers and inaccessible referral pathways [1, 8–10]. They also experience barriers related to limited adjustments in the provision of care to accommodate their needs within services [1, 6, 7]. These barriers not only undermine women with disabilities' capabilities to attain their rights to maternity care on an equal basis with women without disabilities, but also contribute to more disabling experiences due to poorer healthcare access.

Over the past decades, researchers have increased their interest in conducting research on the maternity care experiences of women with disabilities [4, 9, 11–13], and recent studies prioritise respectful maternity care, including disability-inclusive maternity care [14–17]. The World Health Organization have developed the Quality of Care (QOC) framework and called for the elimination of disrespectful maternity care for all women [18–20]. Yet the framework and accompanying guidelines failed to provide guidance on disability-inclusive maternity care.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) conceptualises disability as arising from the interaction between long-term physical, sensory, intellectual and mental impairments with multiple barriers (e.g. physical, attitudinal, communication) that undermine opportunities to participate in society on an equal basis with non-disabled people [21]. Drawing on this rights-based approach, disability-inclusive maternity care can be conceptualised as the rights of women with disabilities to access equitable maternity care that is accessible, respectful and responsive to their individual needs. This requires services and systems to address existing barriers to care and ensure that women with disabilities are fully informed of their rights and support to access the full spectrum of maternity care during pregnancy and childbirth [21–23].

The Royal Government of Cambodia (RGC) and its development partners have invested in strengthening the healthcare system and the capacity of the health workforce to improve maternal health [24–26]. As a result, there has been a substantial reduction in maternal mortality, from 234 per 100,000 live births in 2010 to 137 per 100,000 live births in 2023 [26–29]. Such investment and leadership have demonstrated that reducing maternal mortality is one of the key priorities of the Cambodian Government's commitment toward the Sustainable Development Goals (Goal 3) [30]. Yet equitable access to maternity care remains a challenge for some priority populations, particularly for women with disabilities [1].

Reducing these inequities requires countries to identify and address policy and health service barriers which undermine the effective implementation of disability-inclusive maternity care. Sometimes, policies may reflect intentions to this effect but fall short in their remit and implementation. For example, while Cambodia's National Disability Strategic Plan (NDSP) makes a commitment to "leave no one behind", the plan fails to consider the maternity care needs of women with disabilities. Likewise, these needs are neither articulated nor operationalised within the National Health Policy [27, 30–32]. Consequently, gaps in maternity care provision persist for women with disabilities, contributing to disparities in access and outcomes.

Both Government and non-governmental sectors have an important role in progressing disability-inclusive maternity care. Close collaboration and multidisciplinary approaches are needed to understand how health and non-health factors interact on the ground to influence access to care [33]. Collaborative policy reform with sufficient resource allocation is needed to ensure relevant systems can strengthen capacity to plan, deliver and monitor the effectiveness of disability-inclusive care [23, 34]. Any reform, however, requires an understanding of the perspectives of relevant government and non-governmental stakeholders to identify challenges and propose effective solutions to progress disability-inclusive maternity care.

Our previous research explored the experiences of Cambodian women with disabilities and midwives in accessing and providing disability-inclusive maternity care, respectively [1, 35]. In this follow-up study, we present findings on the perspectives of government and non-governmental stakeholders on the challenges and enabling factors that could inform policy, planning, and practice to enhance disability-inclusive maternity care. This study was conducted in three areas of Cambodia, such as Phnom Penh, Kampong Speu and Kampot. This study also provided us with an opportunity to comprehensively assess the current situation and contribute to

potential strategies to ensure that women with disabilities have equitable access to maternity care in the future.

Methods

Study design

This study adopted a qualitative descriptive approach, using semi-structured interviews to examine the perspectives of stakeholders regarding disability-inclusive maternity care in Cambodia. This approach allows for the in-depth and context-specific exploration of how various stakeholders view this complex issue, including the challenges and possible strategies to advance disability-inclusive maternity care [36–38].

The lead researcher (CV) worked with co-authors (AD, CVa and MM), the Cambodian Midwives Association (CMA), the Cambodian Disabled People's Organization (CDPO) and the leaders of the Organization of Persons with Disabilities (OPDs) in the design and implementation of the study. We followed the COnsolidated criteria for REporting Qualitative research (COREQ) guidelines to outline our methods [39].

Research team and reflexivity

The lead researcher (CV) is a female PhD candidate at the University of Melbourne. She has been awarded an Australian Awards Scholarship to conduct this PhD study. She has extensive clinical experience, having worked as a midwife and nurse in both the public and private health sectors in Cambodia for more than 10 years. She has been passionate about the sexual and reproductive health (SRH) of women with disabilities and engaged in disability field since 2017.

The lead researcher is supervised by three academic supervisors (AD, MM, CVa) who are employed by the University of Melbourne. They have significant expertise in research on disability inclusion, SRHR for women with disabilities, women's health and gender across various LMIC settings, including Cambodia. This paper is part of the lead researcher's PhD thesis and complements interviews with women with disabilities, exploring their maternity care experiences [1] and interviews with Cambodian midwives, exploring their experiences in providing maternity care to women with disabilities [35]. Thus, in this study, we focused on the perspectives of key stakeholders.

Theoretical frameworks

This study draws on the WHO Quality of Care (QoC) framework [18] (see Fig. 1). The WHO developed the QoC framework to assess the quality of care in healthcare facilities and use it as a guide to improve maternity care [18]. This framework has three interrelated components with eight domains, including (1) Provision of care (evidence-based practices for routine care and management of complications, actionable information systems and functional referral systems); (2) Experience of care (effective communication, respect and dignity and emotional support); and (3) Cross-cutting standards (competent and motivated human resources and essential physical resources available) [18]. The WHO QoC framework informed the development of the interview question guide, with a focus on the provision of maternity care to women with disabilities, the challenges and facilitators that healthcare providers experienced when providing care, and relevant policies that may influence the quality of care.

Study site

We conducted our study in three provinces of Cambodia, namely Phnom Penh, Kampong Speu, and Kampot. These provinces were selected in consultation with the CMA chief, CDPO and the chiefs of OPDs in Kampot and Kampong Speu. Furthermore, these sites were selected due to their relevancy to the two previous studies [1, 35] which were also conducted in the same provinces.

Participants and recruitment

Participants were eligible and invited to participate in our study if they were civil servants, including (1) health service providers within leadership roles; (2) policy makers who were currently working for the public sector, under the Cambodian government; or (3) individuals whose roles involved disability inclusion and who were currently employed by Non-Governmental Organizations (NGO).

Participants were purposively recruited through the networks of the CMA, CDPO and Kampot and Kampong Speu OPDs. We initially intended to recruit 15 participants; however, only 12 stakeholders were available for interview in the study timeframe. Our qualitative study did not aim for generalisability [38, 40]; however, we aimed to recruit participants who had the relevant experiences and could provide us with the data that we expected. Hence, this sample size offered us sufficient information power, aligning with the aim of our study [41]. Government stakeholders consisted of governmental policy makers (n = 3) and health service leaders (n = 4). Non-governmental stakeholders included representatives from organizations that engaged in disability inclusion and advocacy (n = 5), most of whom identified as living with a disability. They were chosen because they work closely with the government, advocating for disability inclusion in policy and contributing to the disability strategic plan. Of the 12 participants, seven were male. See Table 1. Urban refers to a metropolitan or city geographical area. Provincial refers to rural areas, defined by the Cambodian National Institute of Statistics [42].

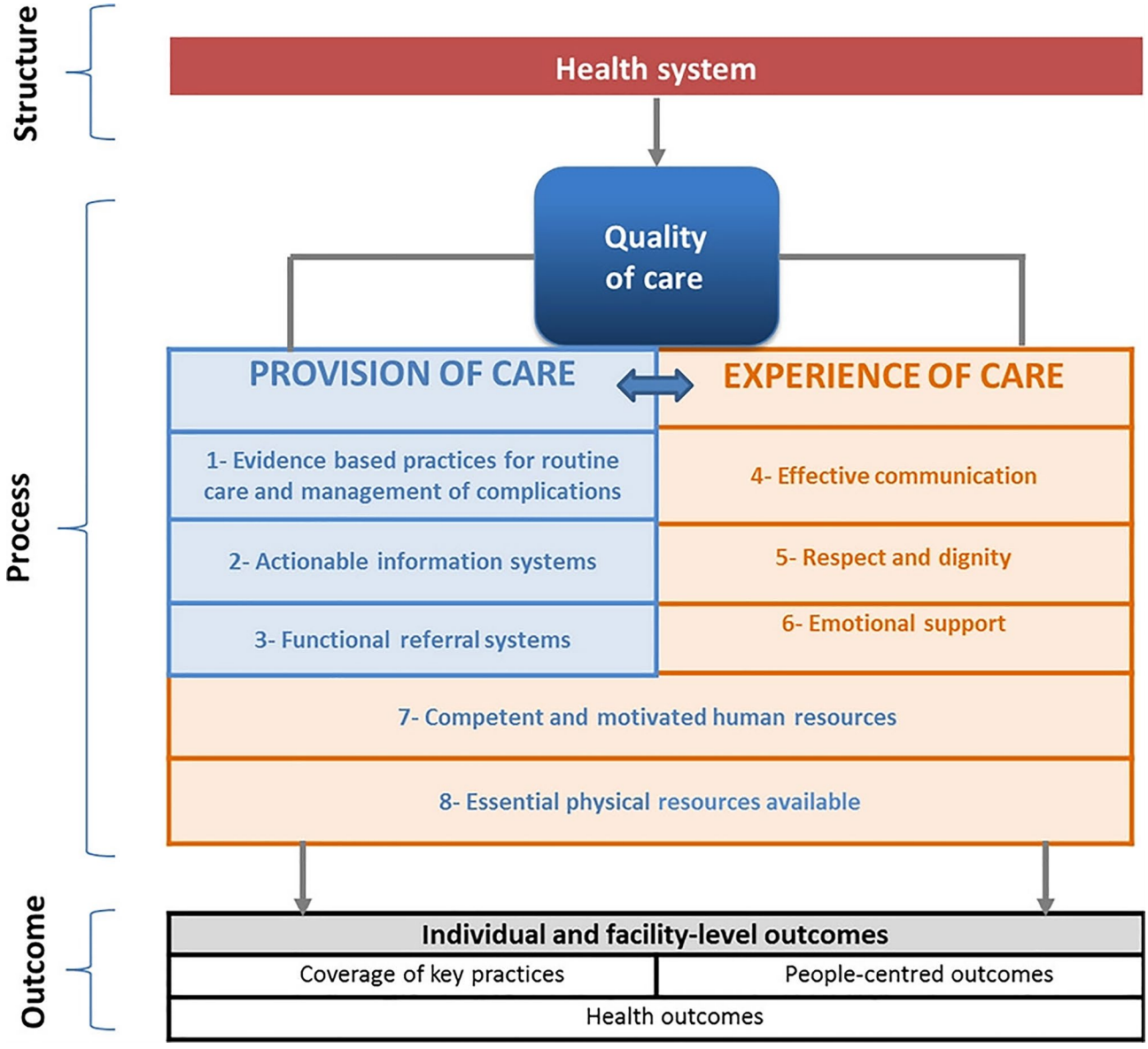

Fig. 1 WHO quality of care framework for maternal and newborn health

Table 1 Participant demographic information

Participant	Sex	Geographical area	Sector	Professional Role/Position
01	F	Urban	Government	Health service leader
02	M	Urban	NGO	Disability organization regional director
03	M	Provincial	Government	Health service leader
04	M	Provincial	NGO	Disability organization leader
05	M	Provincial	Government	Health service leader
06	M	Provincial	Government	Health service leader
07	F	Provincial	NGO	Disability organization leader
08	M	Urban	NGO	Disability organization leader
09	F	Urban	NGO	Disability organization director
10	F	Urban	Government	Policy maker
11	M	Provincial	Government	Policy maker
12	F	Urban	Government	Policy maker

NB: To maintain anonymity, the specific locations and the workplace of participants are not included

Ethics approval

Ethics approval was gained from the Human Research Ethics Committee at the University of Melbourne in Australia (Reference Number: 2023-27188-45631-3) and the National Ethics Committee for Health Research of the Ministry of Health in Cambodia (Approval Number: 345 NECHR). All participants provided informed consent prior to the interview.

Data collection

The first author (CV) collected data from December 2023 to February 2024, using in-depth semi-structured interviews. All interviews were conducted in person using the Khmer language, with most participants opting to be interviewed at their workplace. The average interview time was 46 min (range 30–120 min). The first author developed the interview guide in consultation with co-authors (AD, CVa and MM), the CDPO, OPDs, and the CMA chief. The interview guide was developed specifically for this study (see Supplementary File – Sect. 1) and pilot-tested with two participants from partner organizations, with minor amendments made to simplify and clarify the questions. Although the interview was led by the first author and followed the interview guide, our approach remained flexible to allow participants to expand on their experiences and lead the flow of the discussion. Probing questions and prompts were utilised to encourage further reflection as needed.

Participants were ensured that the interview was not a test of their ability, but rather to understand their perspectives regarding disability-inclusive maternity care. After demographic details were collected, participants were asked open-ended questions regarding their conceptualisation of and perspectives on disability-inclusive maternity care, including potential factors influencing access to and quality of care provided to women with disabilities. Participants were then asked about their perceptions regarding factors that may influence the capacity of midwives to deliver inclusive care. Potential strategies to enhance maternity care for women with disabilities were also discussed. Upon completion, the lead researcher reviewed the participants' responses with each participant to ensure their perspectives had been accurately captured. Field notes were taken on the same day of the interview to reflect initial thoughts, preliminary themes, and support the subsequent data analysis.

Data analysis

Data were audio-recorded, transcribed verbatim and translated from Khmer to English. Each transcript was de-identified, with each participant assigned a number, before being exported to NVivo (Version 14) for thematic analysis [31, 32]. These transcripts were also reviewed by co-authors for both quality checking and familiarising with the data. The first author immersed herself in the data through repeated reading of the individual transcripts, listening to the audio recordings, and reviewing interview notes.

Data were analysed deductively using the WHO QoC framework and inductively using thematic analysis. Candidate themes were derived from the compilation of coded clusters and reviewed by the co-authors to ensure rigour and trustworthiness of the data analysis. The final themes were refined after various discussions among the co-authors and by revisiting the dataset, research questions, and related literature. We also involved CDPOs and OPDs in discussions about the process of data analysis and interpretation, which led to the conclusion of our findings.

Rigor and trustworthiness

Rigor and trustworthiness of the study were ensured through credibility, dependability, confirmability, and transferability [38, 43]. Credibility was ensured through member checking, where the lead researcher reviewed the responding answers with all participants after each interview to ensure that their perspectives were accurately captured. The study's preliminary findings were presented to all participants in workshops to validate the analysis's interpretation. All co-authors also reviewed the accuracy of the English transcripts. The lead researcher held regular meetings with all co-authors, the CDPO, and the OPDs to discuss research progress, review and validate data analyses, and interpret the research findings. Data triangulation was obtained by reviewing transcripts and fieldnotes, and by listening to audio recordings. To ensure dependability, an audit trail was employed to document the research process, including coding frameworks and coding decisions, the development of main themes and sub-themes, analytic memos and field notes. NVivo version 14 was employed as an analysis tool to facilitate data coding and organisation, ensuring consistency and traceability throughout the coding process. Confirmability was ensured by the lead researcher practising positionality and reflexivity, using a reflexive journal and discussing it with the wider research team to avoid any conscious and unconscious bias. Transferability was ensured through exhaustive descriptions of the study's contextual background, specific settings, and methods, including characteristics of research participants.

Results

Findings are presented across five key themes, four of which align with the WHO QoC framework (Table 2). Our analysis revealed systemic barriers related to resources, disability guidelines, policies and accessibility. Key barriers were associated with inconsistent

Table 2 Themes and sub-themes identified from the analysis

Themes	Sub-themes	Summary of the findings
Perception and conceptualisation of disability-inclusive maternity care		Limited understanding of disability-inclusive maternity care among government stakeholders Different views on equal and equitable maternity care Unanimous perspective that current maternity care is not disability-inclusive
Competent and motivated human resources		Limited disability training for midwives Insufficient workforce to accommodate individualised care and support Inconsistent policy and leadership awareness on disability within maternity care
Essential physical resources		Inaccessible facilities Inadequate resources to deliver inclusive maternity care
Provision of care	*Supportive policies and evidence-based practice guidelines related to disability-inclusive maternity care*	Absence of supportive policies and evidence-based practice guidelines related to disability-inclusive maternity care
	Actionable information systems	Absence of disability data collection system, monitoring and evaluation mechanism Absence of training for midwives to disaggregate disability data
	Functional referral systems	Weak referral systems, inaccessible transport, and insufficient resources during emergency transfers
Experience of care	*Respect and dignity*	Discrimination and social stigma undermine women with disabilities' access to respectful and inclusive maternity care Lack of family support due to the shame of the family when women with disabilities get pregnant
	Accessibility of information and communication	Communication barriers, lack of accessible materials, and sign language interpreters The heavy workload of midwives limits the capacity to fulfil the communication needs of women with disabilities The exclusion of women with disabilities from accessing healthcare information within the community The roles of OPDs facilitate and support women with disabilities to access health information
	Affordability of maternity care services	Different perspectives among stakeholders regarding the National Social Protection Policies Inconsistent implementation of Social Protection Policies Ineffective roles of the commune committees in offering support to women with disabilities

understanding of disability-inclusive maternity care, a lack of disability training for healthcare providers, inadequate workforce and essential physical resources, including the absence of disability evidence-based guidelines, policies, and disability data collection systems. Other challenges included unreliable functional referral systems, communication difficulties, inconsistent implementation of social protection policies and discriminatory attitudes towards women with disabilities. These barriers undermined access to respectful, inclusive and dignified maternity care.

Perception and conceptualisation of disability-inclusive maternity care

Government stakeholders often found it challenging to articulate a conceptualisation of disability-inclusive maternity care. With prompting, some described it as care that treats all women equally without discrimination.

> *Disability-inclusive maternity care is the care that includes everyone, regardless of whether women have disabilities or not…care that delivers equal and consistent services to all, and we use the phrase 'We never leave anyone behind'. We must provide maternity care services without discrimination while still providing high quality of care with morality. (P12, Policy maker).*

As expected, non-governmental stakeholders were more readily able to conceptualise disability-inclusive maternity care, aligning their understanding with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), including highlighting the importance of disability rights and the need to remove barriers to care. They further indicated the importance of differentiating between equality and equity. They argued that providing the same maternity care does not equate to disability-inclusive care. Instead, they emphasised that equitable care must address the diverse needs of women with disabilities and the barriers they experience to ensure more equitable accessibility and inclusivity in maternity services.

> *Some healthcare providers always say we provide care to women equally… I think they need to differentiate between equality and equity. If they provide maternity care equally, this is still not disability-inclusive maternity care because they haven't made the services easily accessible for women with disabilities… (P02, NGO).*

Despite recognition of the need for inclusive services, both government and non-governmental stakeholders unanimously agreed that maternity care services are not currently so, highlighting that all women with disabilities would benefit if they were.

> *Maternity care services are only for general women … they're not inclusive…if they make the maternity care services inclusive for women with disabilities, that means those services will be available and accessible for all. (P09, NGO).*

Competent and motivated human resources

Stakeholders overwhelmingly expressed a perception that midwives lack training and sufficient knowledge related to disability. This significant knowledge gap, they argued, could lead to a lack of confidence and motivation among midwives in providing inclusive care. They further advocated for the integration of disability-inclusive maternity care within both pre-service and in-service training.

> *I believe our Cambodian midwives should be trained in disability-inclusive maternity care so that they have sufficient capacity and competence to provide these services. The training should be included in both pre-service and in-service education programs. (P12, Policy maker).*

Some governmental stakeholders shared their view that there were not enough staff to care for women with disabilities. They shared that most health centres were already stretched with limited midwives, and therefore, it was challenging for midwives to offer extra care for women with disabilities. Despite this, there was recognition that women with disabilities would likely require extra time and planning to explain medical procedures and provide care, especially when women came without family support and women with communication difficulties. Ideally, it would be possible to have a dedicated midwife providing ongoing support to women with disabilities, yet this remains difficult due to human resource challenges.

> *Our midwives are quite busy every day. Many large hospitals have many midwives, but in the health centres, there are not enough midwives to provide maternity care services if we arrange for one midwife to work individually with women with disabilities. (P11, Policy maker).*

Limited policy and leadership were also raised as undermining progress on inclusive care. Some government stakeholders involved in health policy acknowledged that there was a disconnect in their role as policy makers and their understanding of the barriers that women with disabilities encounter when accessing maternity care.

> *None of the important stakeholders or key persons have highlighted concerns regarding women with disabilities' barriers to access maternity care in our meetings. The vast majority of the leadership team is less knowledgeable about women with disabilities' maternity care difficulties; they are more familiar with general issues affecting people with disabilities, but not maternity care. (P11, Policy maker).*

The lack of disability awareness and understanding was a concern and became evident when one government stakeholder undermined the reproductive rights of women with disabilities, stating that: *"If a woman has a disability, I think she should not be pregnant. If she was already pregnant before she got the disability, then I think, yes, she can be pregnant, but if she has a physical disability from birth, I think she should not be pregnant."* (P01, Health service leader).

Essential physical resources

Non-governmental stakeholders highlighted that government investment in infrastructure fails to meet accessibility standards. While they reported that some initiatives from the government, such as not charging a fee for women with disabilities for maternity care services, they agreed that more needs to be done to make facilities more physically accessible. As such, inaccessible buildings, restrooms, delivery beds, and a lack of adequate medical equipment and assistive devices were seen as major barriers to inclusive care.

> *Midwives who work in the health centres lack access to sufficient medical equipment. This is a barrier for them to provide disability-inclusive maternity care … it is difficult for midwives to provide maternity care when the health centre or hospital buildings are not physically accessible for women with disabilities. (P04, NGO).*

Conversely, two government stakeholders expressed their views that there were not many women with disabilities accessing the maternity care services. Hence, the improvement of physical accessibility was perceived as not a priority and women with disabilities could depend on their family to assist them in navigating the buildings.

> *I think that although they cannot access our building, their family or relatives can help them with their accessibility and movement. We do not have many women with disabilities to come to our health centre. (P05, Health service leader).*

Provision of care

Supportive policies and evidence-based practice guidelines related to disability-inclusive maternity care

All stakeholders emphasised the lack of policies on disability-inclusive maternity care. While the National Disability Strategic Plan (NDSP) was discussed among stakeholders as a roadmap to enhance disability rights and equitable access to health care more broadly, they identified that the NDSP does not explicitly cover disability-inclusive maternity care and recommended that the government should consider updating it. Some stakeholders were highly motivated to contribute to developing a specific disability-inclusive maternity care policy for Cambodia. They called on the government to integrate disability-inclusive maternity care into the National Disability Strategic Plan.

> *On behalf of policy makers … what is important is that we need policy documentation in the National Strategic Development Plan (NSDP). Our Disability Strategic Plan already consisted of health and gender. Now, we should integrate disability-inclusive maternity care into our national strategic plan … This policy will be implemented by the medical staff. (P10, Policy maker).*

Subsequent to the lack of policy, stakeholders discussed the absence of evidence-based guidelines related to disability-inclusive maternity care. They agreed that evidence-based practice guidelines would support midwives in their clinical practices, while disability-inclusive policies would support midwives in receiving sufficient training and allocating resources to deliver disability-inclusive care.

> *Cambodian midwives still face many challenges when providing maternity care to women with disabilities … The Ministry of Health should develop a guideline for disability-inclusive maternity care and begin training all medical students. We currently do not have any disability-inclusive maternity care policies and guidelines. (P11, Policy maker).*

Actionable information systems

Several stakeholders noted the absence of a system for collecting data on disability within the healthcare system. Without accurate data, they believed that it is difficult for midwives to monitor their service coverage and sufficiently respond to the maternity care needs of women with disabilities.

> *We never record or collect disability data from women…if we have such a recording system…this would enable us to determine how often women with disabilities access our maternity care services and identify the number of women with disabilities in each village. This data will help us to arrange our maternity care to respond sufficiently (P05, Health service leader).*

Almost all stakeholders emphasised the importance of training medical staff to gather disability data accurately and called for the implementation of monitoring and evaluation processes to ensure that the maternity care provided to women with disabilities is safe, effective, and inclusive of their needs. They also noted that data systems would be useful for tracking the implementation of disability-inclusive health care policies, and also for planning the appropriate allocation of resources.

> *We need to have reliable disability data, monitoring and evaluation systems to monitor the practice of healthcare providers when they provide maternity care to women with disabilities … We must also ensure that the policy of disability-inclusive maternity care has been properly implemented with accountability, cost, and effectiveness. (P08, NGO).*

Functional referral systems

Stakeholders raised concerns about challenges that often disrupt already weak referral systems for women with disabilities requiring a higher level of maternity care. Key issues included a lack of accessible transport, human resources and equipment. Some government stakeholders reported that many healthcare providers in remote areas relied heavily on donated Tuk Tuks (autorickshaw) to transport women during emergencies when the ambulances from provincial hospitals were unavailable.

> *We have a Tuk Tuk to transfer women. [Name of NGO] gave us this Tuk Tuk to transfer patients during medical emergencies…We have an oxygen tank from our health centre, but we do not have other medical equipment. We have one midwife to go with the woman when we transfer the woman to the provincial hospital. (P05, Health service leader).*

Various stakeholders discussed that to improve maternity care for women with disabilities, the health system needed to be strengthened with a reliable referral system and an accessible transportation arrangement for women with disabilities.

> *I also suggest that there is enough support in providing transportation arrangements…I also want to have a reliable referral system when women with disabilities need extra support during their access to maternity care. (P07, NGO).*

Other stakeholders also described challenges in referring women with disabilities who required broader health services. Participants highlighted that women with disabilities would need to be able to navigate other service systems on their own to access required services.

> *We don't really have a referral system. If they have cancer, we have such kind of a referral system to other hospitals. But this is a big national hospital, and we only focus on maternity care. If they need another specific support service, we don't refer them; they have to go by themselves. (P01, health service leader).*

Experience of care

Respect and dignity

Government stakeholders stressed that healthcare providers consistently prioritised women with disabilities and treated them with respect and dignity on an equal basis to other women. Conversely, many non-governmental stakeholders expressed a different perspective, raising concerns about the negative attitudes of healthcare providers. Some shared experiences of women with disabilities waiting long hours and not being prioritised by healthcare providers and midwives.

> *Women with disabilities also lack access to maternity care services because once they arrive at the healthcare facility, healthcare providers or midwives do not provide priority to them. They have to wait long hours. (P07, NGO).*

Non-governmental stakeholders also shared that often women with disabilities got pregnant due to sexual abuse, and frequently they did not receive enough support. They believed that cultural attitudes of discrimination against these women who got pregnant without getting married affected women with disabilities seeking timely healthcare. The challenges were exacerbated when some families did not support women with disabilities or accompany them to health centres due to shame. Women with disabilities might also be worried about being stigmatised in the community and at health centres, and therefore, try to conceal their pregnancy and avoid maternity care, which could be harmful for both the mother and the child.

> *Social discrimination, in my opinion, still prevents women with disabilities from receiving maternity care services. People in the community will discriminate against a disabled woman, for instance, if she is not married and becomes pregnant. Because she does not want people to know that she is pregnant without being married, she might attempt to conceal her pregnancy and avoid accessing maternity care … They [women with disabilities] do not just lack emotional support; they also lack physical and social support. (Participant 02, NGO).*

All stakeholders emphasised the need to ensure that women with disabilities have timely access to maternity care and should have experiences of respectful care.

> *When providing maternity care services, healthcare practitioners must prioritise and treat women with disabilities with dignity and respect. Women with disabilities are all human. They have equal rights in accessing maternity care services. (P08, NGO).*

Accessibility of information and communication

Over half of the government and non-governmental stakeholders identified communication as a significant challenge for both women with disabilities and midwives. These challenges were highlighted as particularly pronounced when midwives engaged with women with sensory disabilities and/or intellectual disabilities. Specific barriers described include limited resources and capacity of midwives to communicate information in an accessible manner, and the absence of sign language interpreters or other supports that could help bridge these communication gaps.

> *Midwives never used any pictures or photos to show women with disabilities. They only verbally explained, and it was just a one-time explanation. They never have time to have one-on-one explanations…midwives may face communication difficulties, especially with Deaf women and women with intellectual disabilities due to limited access to enough medical equipment and other communication materials such as pictures and photos… (P07, NGO).*

As described earlier, some government stakeholders recognised the heavy workload of midwives and the challenges in their roles that undermined their capacity to meet the communication needs of women with disabilities. They emphasised the need for collaboration with social affairs departments to provide sign language support for midwives caring for women with disabilities.

> *We must understand that midwives have so many tasks to fulfil already. If it is possible, we need an agency of social affairs to be based in our hospital and to assist vulnerable groups, such as women with disabilities … We do not have this kind of collaboration …This sign language training should be given to the social affairs staff. If we push all our midwives to*

learn sign language, I think it is too much for them… (P03, Health service leader).

Beyond this communication barrier, some non-governmental stakeholders expressed that women with disabilities were also excluded from accessing health information in their communities. For instance, they were rarely invited to attend any health promotion activities in their villages.

Mostly, when healthcare providers or local authorities wanted to do health promotion in the village, they never invited women with disabilities. They overlook them because they thought that these women could not understand their meeting. (P04, NGO).

Responding to this exclusion of women with disabilities, a few OPD stakeholders indicated that they supported the women by providing health information, relevant contact information and supporting them to access maternity care services.

We used to invite women with disabilities to attend sexual and reproductive health training with us so that they could know more about their health. We also provide them with contact information in case they need support from medical staff in their village … We also follow up with them to see whether they go to the health centre or hospital for their ANC. (P04, NGO).

Affordability of maternity care services

Government stakeholders were more likely to perceive that women with disabilities did not encounter financial barriers in accessing maternity care. They praised social protection systems for enabling the availability of free maternity care and transportation reimbursement through ID-Poor cards and disability cards, as well as financial aid from other organizations.

Non-governmental stakeholders, however, consistently expressed their concerns about the financial challenges experienced by women with disabilities that undermine their access to care. They asserted that despite the intention of existing social protection policies to alleviate economic barriers to care, women with disabilities continue to encounter significant affordability concerns. For instance, despite their disability, women were still required to pay upfront for their maternity care, and they were unable to afford their transportation expenses.

Women with disabilities still lack access to maternity care services due to transportation difficulties and a lack of money to pay for maternity care services and transportation fees. Women who use wheelchairs typically incur twice as much in transportation costs since they need to pay for two separate costs: one for themselves and another for their wheelchairs. They also need to pay for someone who accompanies them… (P08, NGO).

Stakeholders from non-governmental organizations further described healthcare providers' inconsistent response to women with disabilities presenting with ID-Poor and disability cards, such as not prioritising their access to care as the policy dictates they should.

I heard that when some women with disabilities accessed maternity care services while using their ID-Poor cards, the healthcare providers kept them waiting very long and did not welcome them. (P02, NGO).

One non-governmental stakeholder also pointed out the inadequate support for women with disabilities at the local level, emphasising the ineffective roles of commune committees in offering assistance within their communities.

In each community, we have a commune committee for women and children. This committee is supposed to provide social and financial support to vulnerable women and children, including women with disabilities. However, we can see that women with disabilities still lack this support in their community. The committee focuses more on infrastructure rather than providing sufficient social services and financial support to women with disabilities. (P08, NGO).

Discussion

This study contributes to our broader research on maternity care in Cambodia, which found that the rights of women with disabilities to access maternity care remained largely unattained [1], with midwives seeking more knowledge, resources and support to improve their provision of care for this population [35]. This is despite the country's ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and progress towards disability rights in Cambodia [31, 32, 44]. In this study, government policy makers, health service leaders, and non-governmental organisation stakeholders were interviewed regarding their perspectives on access to maternity care for women with disabilities and how progress can be made. The study added to the critical evidence on current factors influencing access to disability-inclusive maternity care services.

Our findings highlight that disability-inclusive maternity care has not been institutionalised into relevant

policies, such as healthcare policies and the National Disability Strategic Plan. These policy gaps contribute to systemic barriers to adequately resourcing investments in accessible facilities, training, and capacity building of midwives, as well as the development of evidence-based guidelines relating to disability-inclusive maternity care. The absence of clear guidelines and disability training consequently places an undue burden on midwives, who frequently feel unprepared, lacking in confidence and motivation to provide maternity care services for women with disabilities [35, 45–47]. These issues are compounded by workforce shortages of midwives more broadly. Our findings echo previous studies that highlight the challenges that healthcare providers encounter in delivering maternity care to women with disabilities, particularly due to the lack of medical staff, the absence of evidence-based practice guidelines, policy and training pertaining to disability-inclusive maternity care [35, 46–50].

Contributing to these systemic and policy gaps, our study also indicates that some government stakeholders lack clarity in their understanding of disability-inclusive maternity care. In contrast, non-governmental stakeholders working in the disability sector, particularly stakeholders with lived experiences of disability, offer a more nuanced understanding and perspective on this topic. This aligns with the findings of the United Nations Educational, Scientific and Cultural Organization (UNESCO), which found that there was a limited understanding of disability inclusion among government staff across the national and sub-national levels [51]. Furthermore, some government policy makers were not aware of the barriers that women with disabilities experienced. Some oversimplified that women with disabilities had no challenges in accessing care due to the social protection policy, which offers women with disabilities access to maternity care without charge and transportation reimbursement [52]. As in other settings, these knowledge and awareness gaps are more likely to contribute to the observed lack of political will and leadership in developing, resourcing, implementing and monitoring policies and programs that would support disability-inclusive maternity care for this priority population [53]. This also has negative implications for service delivery and resource allocation. For instance, without a clear policy direction and political commitment, maternity care for women with disabilities is overlooked in the process of planning and budgeting, which subsequently contributes to continuous health disparities for women with disabilities.

Our study also reveals inconsistencies in the implementation of Cambodia's National Social Protection Policy Framework (NSPPF) and its key mechanisms through the provision of ID-Poor and disability cards to access free maternity care. While some government stakeholders view NSPPF as a dynamic initiative to remove financial barriers for accessing maternity care, non-governmental stakeholders point out various obstacles, such as challenges in navigating the system to obtain benefits despite eligibility, a lack of prioritisation to access care, and unwelcoming attitudes from healthcare providers when women with disabilities use these cards to access maternity care. When government policy makers, health service leaders and disability stakeholders view things differently on the policy implementation and fail to consistently apply a disability lens to health and social welfare policy, the flow-on effect is inadequate resources and training, which can negatively affect the capacity of midwives and the maternity care experiences of women with disabilities. Similar to the wider literature, our study indicates that although the NSPPF has the potential to improve the inclusion of women with disabilities in accessing maternity care, the implementation has been inconsistent and frail [54, 55]. The Cambodian government should take action to reinforce disability policy implementation on the ground and monitor to ensure that service providers implement the cards as intended and that women with disabilities understand their rights to the cards when accessing maternity care. Our findings reverberate with recent research conducted in Cambodia, which found the same challenges for women with disabilities in obtaining ID-Poor and disability cards, including the challenges in using these cards to access maternity care services [1] and issues related to the social exclusion of people with disabilities [56], particularly within the rural contexts of Cambodia.

A multifaceted and collaborative approach between all stakeholders, including women with disabilities and their representative organizations, is needed to inform policy reform and implement strategies to enhance service delivery and access to disability-inclusive maternity care. Based on the findings from this study, there are three key policy actions that the Cambodian government should prioritise. Firstly, policy reform is essential to explicitly incorporate disability-inclusive maternity care into the NDSP and the national health policies, establishing an institutional and legal framework to support maternity care for women with disabilities. Secondly, the government of Cambodia, especially the Ministry of Health, should strengthen the health system by focusing on greater investment in accessible facilities, robust referral systems, capacity building for the health workforce, and improving the knowledge and leadership on disability inclusion among policy makers and health service leaders, as they are considered good practice examples for the disability-inclusive health systems [23]. Thirdly, it is also essential to establish a reliable disability data collection system with effective monitoring and evaluation [35].

More broadly, disability inclusion and awareness should be implemented and incorporated at all levels of educational and healthcare institutions to eliminate discrimination against women with disabilities [57]. Our findings highlight that there is a lack of social attention on maternity care for women with disabilities in Cambodia, reflecting the continuous neglect of their sexual and reproductive health rights [58]. Our study resonates with the recent study, published in the Lancet, which indicated that the health system has not adequately responded to the healthcare needs of persons with disabilities [34]. It is now an opportunity for the Cambodian government to engage relevant government and non-governmental stakeholders in developing and enacting a disability-inclusive maternity care policy, while continuing to build on the success in promoting maternal health that truly reflects inclusive care for women with disabilities.

Our study is the first qualitative study conducted in Cambodia to explore the perspectives of diverse key stakeholders on disability-inclusive maternity care. The study provided rich data and added to the gaps in evidence of maternity care for women with disabilities in Cambodia. The findings of this study could be used as evidence to inform policy, planning and practice to enhance disability-inclusive maternity care for Cambodian women with disabilities. Our study has some limitations. The study was conducted in only three areas of Cambodia and focused on public health services. The samples were purposively selected. We acknowledge that their perspectives do not represent all relevant stakeholders engaged in the disability-inclusive maternity care sector in Cambodia. Hence, the findings of our study may limit its generalisability to other contexts. Additionally, there could be a social response bias to promote positive things about the system despite challenges identified by non-governmental stakeholders. Furthermore, the power dynamics between the researcher and participants, particularly with government stakeholders (policy makers), may have influenced the depth and openness of the discussions. Finally, despite careful attention to translating data from Khmer to English, some linguistic nuances and specific meanings embedded in Cambodian society and culture may have been lost.

Conclusion

All key stakeholders expressed their perception that the current maternity care services for women with disabilities are not disability-inclusive. While women with disabilities experience systemic barriers in accessing maternity care services, healthcare providers such as Cambodian midwives encounter substantial challenges in providing disability-inclusive maternity care. To address this social issue, it is recommended that the government of Cambodia collaborate with relevant stakeholders to develop policies, guidelines and training curricula related to disability-inclusive maternity care for healthcare professionals, including midwives. This should be done with strong leadership and political will, with the involvement of women with disabilities in the process. Many stakeholders expressed their strong intention to get involved in supporting these activities, which is a great initiative and opportunity for multi-stakeholder collaboration to ensure that women with disabilities are not left behind when accessing maternity care.

Abbreviations

CDPO	Cambodian Disabled People's Organization
CMA	Cambodian Midwives Association
COREQ	COnsolidated criteria for REporting Qualitative research Guidelines
NDSP	National Disability Strategic Plan
NGO	Non-Governmental Organizations
NSPPF	National Social Protection Policy Framework
OPDs	Organization of Persons with Disabilities
QoC	Quality of Care
RGC	The Royal Government of Cambodia
SRH	Sexual and Reproductive Health
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

Supplementary Information

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Supplementary Material 1

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Author contributions

Champamunny Ven (CV): Conceptualisation (Lead), Data curation, Formal analysis (Lead), Investigation, Methodology (Lead), Project administration, Software, Validation, Visualisation, Writing– original draft (Lead), Writing – review & editing. Manjula Marella (MM): Conceptualisation, Data curation, Investigation, Methodology, Supervision, Validation, Visualisation, Writing – review & editing. Cathy Vaughan (CVa): Conceptualisation, Investigation, Methodology, Supervision, Validation, Visualisation, Writing – review & editing. Alexandra Devine (AD): Conceptualisation, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Visualisation, Writing – review & editing.

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Data availability

All data analysed in this study are only available to researchers involved in this study due to ethical reasons.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the Human Research Ethics Committee at the University of Melbourne in Australia (Reference Number: 2023-27188-45631-3) and the National Ethics Committee for Health Research of the Ministry of Health in Cambodia (Approval Number: 345 NECHR). All participants interviewed in this study provided informed consent to participate in the interview. At every stage of our study, we adhered to ethical principles, ensured the privacy and confidentiality of our research participants and protected all data in accordance with the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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