UNIVERSITY FOR DEVELOPMENT STUDIES

CHALLENGES ASSOCIATED WITH PATRONAGE OF SKILLED DELIVERY SERVICES BY PHYSICALLY CHALLENGED WOMEN IN THE TAMALE METROPOLIS

BY

AKUBORI DIANA

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DISSERTATION SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH AND FAMILY MEDICINE, SCHOOL OF MEDICINE AND HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE

FEBRUARY, 2020

DECLARATION

Student

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere:

Candidate's Signature: .... Date: ....

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Supervisors

We hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

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ABSTRACT

The United Nations' Convention on the Rights of Persons with Disabilities guarantees persons with disabilities the same level of right to access quality and affordable healthcare, including sexual and reproductive healthcare services, as persons without disability, unfortunately, persons with disabilities are still one of the most marginalised and socially excluded groups in many countries including Ghana. The objective of this study was to explore the challenges associated with patronage of skilled delivery services by physically challenged women in the tamale metropolis. A cross-sectional qualitative study was conducted among 12 physically challenged women. Data was collected using semi-structured questionnaire through interviews. The physically challenged women were interviewed and additional interviews were conducted among their husbands/relatives and midwives as a complementary information. A snow ball sampling method was used to select eligible respondents. The data were analyzed using a thematic framework approach. Seventy-five per cent of women with disability interviewed said they delivered their last child in a health facility assisted by a health staff. About 92% indicated that, deliveries conducted by midwives in health facilities are described as skilled deliveries. Staff attitude, cost of services, inadequate family support, the attitude of other health seekers and lastly, infrastructure not being disability friendly were the major challenges faced by physically challenged women in accessing skilled delivery services: About 83% indicated that provision of skilled delivery services in the study area was bad. Knowledge of physically challenged women on skilled delivery services was fairly high whiles patronage of skilled delivery services was slightly low among disabled women in the study and are due to challenges such as negative staff attitude, cost of services, inadequate family support, the attitude of other health seekers and infrastructure not disability-friendly. In order to improve the prevailing situation, the Ghana Health Service should provide the needed infrastructure and also intensify its campaign on the need for every pregnant woman, including physically challenged women in labour to be attended to or supervised by a skilled attendant.

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DEDICATION

I dedicate this thesis to my beloved family for their inspiring encouragement and support throughout the study period.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Disability may be defined as the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental, or some combination of these that result in restrictions on an individual's ability to participate in what is considered "normal" in their everyday society (WHO and World Bank, 2011). Globally, persons with disability constitute about 15% of the world's population (WHO and World Bank, 2011). Disability serves as a multi-definition that is associated with people who have mental, physical and intellectual challenges. Disability has also been classified into biomedical and social modes. In reference to biomedical modes, it means a disability that is associated to medical challenges and social modes refer to disability that is associated with social challenges. Literary disability can be defined as ‘‘a fixed condition of preset illnesses which cannot be changed’’ (Smith, 2009:15). This definition may have been debatable because the advancement of technology has brought about positive development to medicine. And this has further brought about changes to the world of disability. This can be associated with disabilities that have been corrected by medical procedures. To this end, disability can also be defined as any form of impairment that negatively affects the ability of a person to function by and large.

In the contemporary times, the phenomena do not only refer to the above mentioned but also many studies have confirmed that disability has more to do with different fields of definitions such as political and economic disability as well.

People with such challenges have been given specific names referring to specific parts of the body that have been impaired. A title such as handicapped is referred to as one whose upper limbs cannot function normally. Also, people with defects have been experiencing social-psychological problems in society in the sense that society defines them as function-less and that they cannot positively contribute to society (Smith, 2009). Thus they live in isolation and exclusion. The United Nations Convention on People with Disabilities has precisely given a broader definition that entails all forms of disabilities as; "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'' (United Nations, 2015: 8). Although the United Nations' Convention on the Rights of Persons with Disabilities guarantees persons with disabilities the same level of right to access quality and affordable healthcare, including sexual and reproductive healthcare services, as persons without disability (United Nations, 2006), such persons are still some of the most marginalised and socially excluded groups in many countries including Ghana (Hosseinpoor et al., 2013; Miltra et al., 2013). This disadvantage transcends several spheres. For example, persons with disabilities have generally poorer health, lower education achievements, fewer economic opportunities and higher rates of poverty than persons without disabilities (WHO & World Bank, 2011). In particular, women with disability are more likely to be poorer and have lower social and economic status than their counterparts who have no disability (Hosseinpoor et al., 2013; Miltra et al., 2013). In the context of reproductive health, Physically challenged women have largely been ignored in reproductive health research and programming (Morrison et al., 2014). For example, one recent review on disability in sexual and reproductive health policies and research in Ghana concluded that persons with disabilities have received little attention (Mprah et al., 2014). Part of the reason for this neglect is that they are often thought not to be sexually active, and less likely to marry or to have children than women without a disability (Ahumuza et al., 2014). The perception that women with disability are not sexually active has often resulted in limited access to sexual and reproductive health services for them. As recent studies show, access to sexual and reproductive health services by women with disability is still a serious challenge (Morrison et al., 2014; Ahumuza et al., 2014). A number of studies have suggested negative social attitudes and cultural assumptions such as the equation of sexuality to being normal and not disabled, physically inaccessible health facilities, insensitivity of healthcare providers, limited knowledge by healthcare providers about disability, and limited information tailored to their health needs as factors hampering access to skilled reproductive and maternal healthcare services by Physically challenged women (Ahumuza et al., 2014; Morrison et al., 2014 and Mulumba et al., 2014). Increasingly, there is a growing body of work in high-income countries that address the health needs, challenges and barriers to reproductive care services by physically challenged women (Morrison et al., 2014; Leigh et al., 2004).

In developing countries, however, there is a paucity of research that asks women with disability about the barriers they encounter in accessing and using maternal healthcare services including deliveries attended to by skilled health care providers (Morrison et al., 2014). In Ghana for example, a number of recent studies have explored various disability issues, including disability culture in Ghana (Reynolds, 2010), the challenges and opportunities of implementing the World Report on Disability (Tuakli-Wosomu & Haig, 2014) and the inclusion of disability in sexual and reproductive health policies and research in Ghana (Mprah et al., 2014). Notwithstanding this growing body of research, we are not aware of any studies in Ghana that have examined the problems of women with disability encounter when accessing and using skilled delivery services. The objective of this study is to explore the challenges women with disability in the Tamale Metropolis face in accessing and using maternal healthcare services.

1.2 Problem Statement

International academic communities, clinical experts, and activists for people with disabilities agree on the importance of access to health care services, and they argue that appropriate health care should be guaranteed for the entire population (Clancy & Andresen, 2002). In respect of this recognition, the United Nations' Convention on the Rights of Persons with Disabilities guarantees persons with disabilities the same level of right to access quality and affordable healthcare, including skilled delivery services. Ghana is a signatory to the United Nations' Convention on the Rights of Persons with Disabilities, and in furtherance of this, Ghana enacted the Persons with Disability Act (Act 715) in 2006 which guarantees persons with disability the right to access the same or specialised range, quality and standard healthcare as provided to other persons, including those in the area of sexual and reproductive health.

However, notwithstanding all these recognitions, conventions and Act 715 on people living with a disability, persons with disability are still one of the most marginalised and socially excluded groups in many underdeveloped countries including Ghana. Their disability exposes them to poorer health, lower education achievements, fewer economic opportunities, high rates of poverty and limited access to services such as skilled delivery, than persons without disabilities. Also, vehicles and most health facilities in the study area are not disability friendly and this poses a big challenge to disabled women in accessing skilled delivery services.

Additionally, in the context of reproductive health, physically challenged women have largely been ignored in reproductive health research and programming (Morrison et al., 2014). In the Tamale Metropolis, just as in Ghana, there is sparse research information about the barriers disabled women encounter in accessing skilled delivery services. Some few pieces of research undertaken in developing countries recognise that access to healthcare services is challenging even for non-disabled women due to poverty and vulnerability (Trani et al., 2011), and disabled women experience even greater challenges in accessing the health system. Commonly reported in the literature are the lack of disabled parking areas, the absence of wheelchair-accessible ramps, and in some cases, a lack of elevators. External factors such as poor design and inadequate examination equipment make healthcare services inaccessible for physically challenged women. The relative ignorance of health workers, being insufficiently educated about disability and unaware of the impact that disability has on individuals, also acts as a barrier to access (Dudley & Emery, 2014). Further, society's interpretation of personal limitations when an individual fails to succeed in the environment adversely influences an individual's experience of disability (Mullner, 2009). Financial difficulties create another major impact on people with disabilities. Families with low socioeconomic status cannot afford expensive healthcare services (WHO, 2005; Xu et al., 2007). Inadequate government support and community involvement, stigmatization and lack of regulatory action all add up to the challenges. Specific challenges that physically challenged women in the study area face when accessing delivery services cannot be found in the literature. It is against this background that, this study seeks to explore the area-specific challenges that physically challenged women face in accessing skilled delivery services in the Tamale Metropolis and make the findings and the recommendations available for policy and improving service delivery.

1.3 Research questions

1. What is the level of knowledge of physically challenged women on skilled delivery services in the Tamale Metropolis?
2. What is the level of patronage of skilled delivery services among physically challenged women in the Tamale Metropolis?
3. How do physically challenged women perceive skilled delivery services in the Tamale Metropolis?
4. What are the challenges that physically challenged women face in assessing skilled delivery services in the Tamale Metropolis?

1.4 Research objectives

1.4.1 Main objectives

To explore the challenges that physically challenged women face in accessing skilled delivery services in the Tamale Metropolis

1.4.2 Specific objectives

1. To assess the level of knowledge of physically challenged women on skilled delivery services in the Tamale Metropolis.

2. To determine the level of patronage of skilled delivery services among physically challenged women in the Tamale Metropolis.
3. To explore the perception of women with disabilities on skilled delivery services in the Tamale Metropolis.
4. To describe the challenges that physically challenged women face in assessing skilled delivery services in the Tamale Metropolis.

1.5: Conceptual framework

The conceptual framework for this study is adopted and modified from a relevant recent contribution to defining and measuring access to health care by Amin et al. (2012). The study will be designed and conducted within this conceptual framework as illustrated in Figure 1. The variables developed under this framework will be used to generate the result of the study.

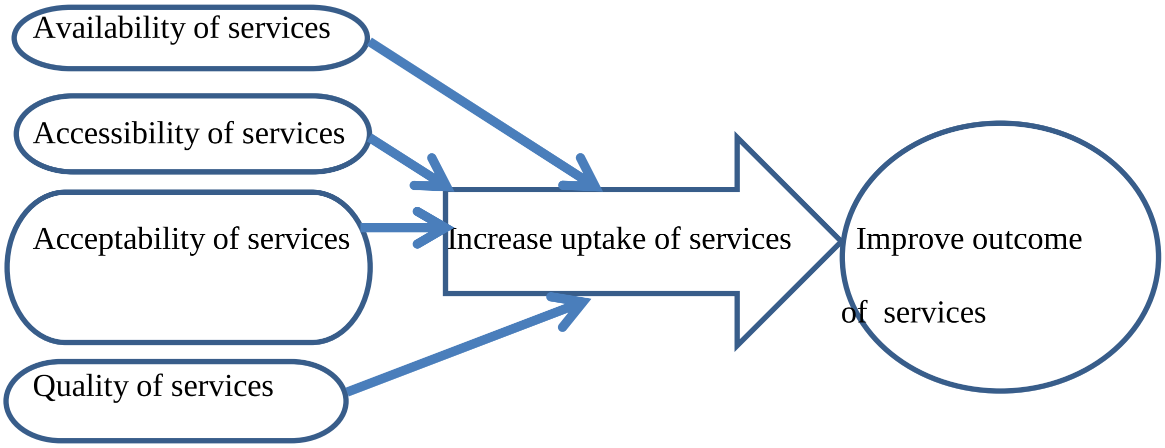

Figure 1.1 Conceptual framework (modified from Amin et al., 2012)

The designers of this equitable framework, basing their approach on existing literature, state that equitable access services are those that meet the needs of all people and are measured using the components in the framework.

1.5.1 Availability: Availability is a concern with the quantity of service available; functioning public health and health care facilities, goods, and services, as well as programmes, have to be available to the general public in sufficient quantity. In the context of this study, availability of maternity homes/units, availability of trained staff and availability of delivery equipment will influence the patronage of skilled delivery services by physically challenged women.

1.5.2 Accessibility: Accessibility as a component refers to the need for health facilities, goods, and services to be accessible to everyone without discrimination, and within the jurisdiction of the State. This element of accessibility has been further broken down into the related dimensions of Non-discrimination; Physical Accessibility; Economic Accessibility (affordability); Information Accessibility and Availability of Social Network and Support. If physically challenged women are not discriminated against, have easy and fast physical accessibility, are economically sound and have access to the needed information about skilled delivery, they may be more willing to patronise skilled delivery services.

1.5.3 Acceptability: Acceptability stresses that all health facilities, goods and services must be respectful of medical ethics, be culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned. If delivery services provide to physically challenged women are in agreement with the laid down ethical protocol and non-discriminately, then this group of women will repeat utilizing killed delivery services.

1.5.4 Quality: Quality here means that health facilities, goods, and services must be scientifically and medically appropriate to provide services of good quality to the targeted clients. If appropriate technologies and services are offered to assist physically challenged women to deliver by skills delivery service providers, then this will have a positive influence on their choice of delivery site. When these components are in place for physically challenged women, there will be the possibility of increase skilled delivery and the result will be an improvement in delivery outcome.

1.6 Significance of the study

This study is intended to gather the healthcare experiences of physically challenged women as a community of interest. It is expected that the results could be used to gauge the urgency that is needed to address the issue of challenges that physically challenged women face in accessing delivery services. Disability is more disadvantageous for women, even though they are more interested in educating themselves about their condition and incorporating this knowledge into healthcare practices (Broom & Tovey, 2009; Wilkins & Savoye, 2009). This study uses a qualitative design to describe both the experiences and the beliefs of physically challenged women (Yin, 2010). This research approach encourages investigators in the field to listen and recognise the important themes for this population, especially in daily life and does this by conducting individual semi-structured interviews with participants. For this study, this will be accomplished by conducting interviews with selected physically challenged women to determine their unmet health needs. This research is designed to help streamline policy content and development, and thereby to address the health needs of physically challenged women in the Tamale Metropolis. Furthermore, this study adds value to feminist perspectives, because focusing on women will produce richer information and specific identification of their needs and experiences. Acknowledging women's experiences and uncovering their concerns may strengthen women's positions in society and their sense of self (Worell & Remer, 2003). As active collaborators for the study, this process is expected to empower participants through them making comments, asking and answering questions and giving opinions, recognising that these women are the experts in this field (Hesse-Biber, 2012). They need to be confident in their ability, self-reliant, independent and have the courage to disregard the discouragement from society. Participation in the study could increase their confidence and motivation due to the sharing of their knowledge, empowerment, and social action with each other. This study is concerned about and intends to bring out, the voices of women who are still marginalized and invisible to research social change, and governmental regulations (Fonow & Cook, 2005).

1.7 Definitions of key terms

Access - in the context of this study, access refers to the right or opportunity for easy approach, entry, contact, and use of the appropriate comprehensive skilled delivery services by physically challenged women

Disabilities- reflecting the consequences of impairment in terms of functional performance and activity by the individual; disabilities thus represent disturbances at the level of the person.

Handicap – meaning hindrance; that is, something that hinders or is a disadvantage to somebody or something.

Impairments – concerned with abnormalities of body structure and appearance and with organ or system function, resulting from any cause; in principle, impairments represent disturbances at the organ level.

Patronage – in the context of this study, refers to the utilization of skilled delivery services

Skilled delivery – refers to a delivery that is assisted or conducted by a trained health professional such as a doctor, nurse, midwife, or community health officer.

1.8 Chapter arrangement

The study involves an exploration of the challenges associated with patronage of skilled delivery services by physically challenged women in the tamale metropolis, Ghana. The report was organized into six (6) chapters, each chapter containing subheadings and details of the content. The organization of the work began with an introductory chapter (chapter one), describing the background of the study, the problem statement, research questions, general and specific objectives, theoretical framework (Interpretative phenomenological analysis) and the justification of the study. Chapter two, which is the second main heading of the report focused on the review of relevant and related literature to the topic under study. The chapter provided an overview of the review and elaboration of what disability is using the disability models. Literature was also reviewed to address the objectives of the study. The methodology section, which is chapter three (3) of the thesis, provides an elaborate outline on how the study will be conducted and is divided into several parts including; study design, background information of study area, study population, sampling size, sampling technique, instrument for data collection and data collection procedure, quality control, pre-testing of instrument, data analysis, limitations of the study and the plan for dissemination of results. Chapter four is a chapter that presents the results of the study. It is categorized according to the study objectives and includes; background of the study respondents, knowledge of physically challenged women on skilled delivery services, patronage of skilled delivery services by physically challenged women, perception of physically challenged women on skilled delivery services and challenges faced by physically challenged women in assessing skilled delivery services. Chapter five covers the discussion and chapter six captures the summary, and conclusions based on the results of the study. This chapter also includes the recommendations that are based on the results and what need to be done.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter seeks to review all relevant literature that complements access and trends of skilled delivery among physically challenged women. The literature review will cover key definitions that would be used in the course of the study. In this regard, assess the level of knowledge of physically challenged women on skilled delivery services in the Tamale Metropolis; ascertain the level of patronage of skilled delivery services among physically challenged women; explore the perception of physically challenged women on skilled delivery services; and determine the challenges that people with disabilities faced in assessing skilled delivery services in the Tamale Metropolis. Other policies and interventions which have been formulated and implemented to bridge the accessibility gaps of all health seekers will also be reviewed.

2.2 Understanding Disability

There is no universal definition of disability in the literature (Meade et al., 2015). This is partly, but not solely a product of the fact that there are so many theoretical approaches to understanding disability (Barnes et al., 2010). Disability is a concept that encompasses health and social problems and is frequently seen through medical and social perspectives. According to Denzin and Lincoln (1985), there are difficulties defining the complexity of disability because of the disagreement over disability as a concept.

Differences in perceptions, various models and classification systems, and variations in understandings accross national and cultural contexts all may result in different definitions of disability (Murthy et al., 2014). Disability is complex, dynamic, multidimensional and contested (WHO, 2011) and has not been defined, measured, or analysed in a consistent manner (Ganle et al., 2015). Because disability covers many contexts each with their own perspectives – e.g., social, economical, health, political – "causes conflict, contradiction, and confusion among terms" even within particular contexts themselves (Dewsbury et al. 2004). A further challenge is that we tend to view disability as a permanent and dichotomous entity, but it is more "fluid and continuous" (Pfeiffer, 1999, p. 394). Definitions seem to be purpose-specific (Dewsbury et al., 2004).

Disability has "been subject to many definitions in different disciplines and for different

purposes" (Mitra, 2013, p. 236). Bennett (1995) believes that these problems originate from inadequate theorising within the field of disability research. As Shildrick (2012) states, disability remains very complex and difficult to define. Understandings of disability have also shifted considerably over time (Graham et al., 2014). According to the United Nations Convention on the Rights of People with Disabilities (UNCRPD), disability remains as "an evolving concept". According to Dewsbury et al. (2004) disability is a word without a specific single meaning because it has been used to represent many different things. According to the ICF, functioning and disability are seen within a dynamic interaction between health conditions as well as personal and environmental contextual factors. Disability is the overarching term for impairments, activity limitations and participation restrictions. These refer to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (Goodley, 2011).

- An impairment is a problem in body function or structure;
- An activity limitation is a difficulty encountered by an individual in executing a task or action;
- A participation restriction is a problem experienced by an individual in involvement in life situations (WHO, 2011).

Hence disability is a complicated issue in that it looks at an interaction between features of a person's body as well as aspects of the society in which he/she finds him/herself. As argued by Murthy et al. (2014) the resulting ICF represents the integration of the Medical and Social models to form a Bio-psychosocial model. The ICF emphasised the universality of disability (Iezzoni et al., 2010). The Preamble to the UNCRPD stresses that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others" (WHO, 2011, p. 4). Defining disability as an interaction means that "disability" cannot be attributed to the individual alone. The potential barriers that affect persons with disabilities can be addressed by improving social participation (WHO, 2011).

According to (Bennett, 1995), to be able to stand up to scrutiny, a definition of disability should be: applicable to all people, without segregation into groups such as "the visually impaired" or "wheelchair users" or those with a chronic illness, and be able to describe the experience of disability across many areas of functioning.

The definition should allow comparison of severity across different types of disability, be flexible enough for different application (e.g., statistical or clinical use), be able to describe all types of disability, and recognise the effects of the environment on a person's disability. Finally, the definition should not include stipulations about the causes of any disability (Dewsbury et al., 2004).

The proposed definition put forward by these authors is: Disability is a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors. (Dewsbury et al., 2004)

However a complicating factor in definition and measurement is that there is no clear distinction between those with disabilities and those without disabilities (Dewsbury et al., 2004). Although disability is primarily seen as a dichotomous situation – either a person is disabled or not – this is not the reality. People may experience disability in one specific situation but not in another, depending on what is required of them. The environmental situation and what the objective of the definition used to describe the situation become important (Dewsbury et al., 2004).

The problems with defining disability have repercussions on

1. How it is measured; and
2. The resultant prevalence rates, amongst other statistics.

As Bennett (1995) mentions, the complex theories and models of terms such as disability can make empirical representations rather difficult. There is, however, a need for empirical disability research in low- and medium-income countries and to strengthen and support research on disability (Graham et al., 2014). Lastly, according to Krahn et al. (2015, p 199) definition differences also reflect an "evolution in our understanding of disability and its relationship to health, the relative value society has placed on people with disabilities, and how program eligibility or legal protections have been addressed". This creates some difficulties for researchers and it must be acknowledged that whatever definition is used must be provisional, the freezing of complex debates into a narrow set of categorizations which may be the most practical to use at a particular time. The shifting perspectives from medically oriented points of view to environment-oriented opinions have been generated, in part, by the deprivation and oppression experienced by persons with disabilities. The disability revolutionary view, to resist oppression, proposed a new perspective that is beyond disability. The new concept proposes that disability is not only a medical concern; but also a societal and environmental concern. These perspectives need to be integrated to support persons with disabilities against unnecessary disablement. The World Health Organization (WHO) classification of disability includes three key factors: impairment, disability, and handicap (Donovan, 2010). Underlying the classification is the concept of an individual's ability to participate in social relationships, the environment and in activities, which may be affected to varying degrees as a result of functional differences. Those three components are derived from various perspectives of disability such as the medical and social models.

2.2.1 Medical model

The medical model originated from the work of the WHO through the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) (WHO, 1980). It provided a perspective that portrays disability as a disease or illness, even though it may not be curable, and hinges on the individual's physical condition. The International Classification of Impairments, Disabilities, and Handicaps (ICIDH) view disablement as a result of diseases or illnesses that require interventions. It refers to 'persons with disabilities', which derives from the idea that at the core of disability is a disablement that can be eliminated with proper medical intervention (Oliver, 1990). It suggested that medical research and experimental interventions will work best to normalise persons with disabilities. Cure and/or rehabilitation is undertaken to assist and manage the illness and its disability. Thus, the expected result is that the intervention could fix people with disabilities so they can function normally. Normal function is the focus. In agreement with the ICIDH definition of disabilities, many researchers have focused heavily on the medical perspective for the core concept of disability by concentrating on diagnoses, treatments, and health policies (De Campos, 2011; Schaaf, 2011; Shakespeare & Watson, 2001). Through these studies, it was reported that many governmental agencies supported the medical model. This support is visible through the implementation of disability programs under the Ministry of Health and the Ministry of Social Welfare of the countries studied (Rothman, 2010). On-going disability programs by governments are implemented, focusing on the medical model combined with the charity framework, which distinguishes the physical condition via a diagnosis, e.g., impairment, and the impact of impairment on function. In reality, this trend led to the recognition that further understanding of disability is required in order to achieve desired outcomes. Factors related to disability, such as age, gender, and sociocultural norms (WHO, 1980) are not identified through this approach. Thus, it is clear that the medical model or framework is limited by regarding disability as a medical issue, only to be viewed within the realms of healthcare. The challenges of the implementation of policy based on the medical model in Latin America were pointed out by Gatjens (2011). According to his study and analysis, the lead governmental agency for disability was the Ministry of Health. It was responsible for the implementation and monitoring of the Convention on the Rights of Persons with Disabilities programs in Latin American countries. The Ministry of Health was considered to have extensive knowledge of medical issues; therefore, people with disabilities having medical problems required management by the Ministry of Health (Gatjens, 2011). In his review, Gatjens (2011) suggested that disability programs and interventions by the Ministry of Health had not provided satisfactory outcomes and failed to seek inter-agency collaboration, nor integration through the involvement of persons with disabilities and were, therefore, unable to successfully convey and implement the programs' objectives The perspective of disability as an illness requiring only medical intervention to be normal no longer fits with the experiences of the person with a disability. Rather than being significantly helpful, medical intervention could conversely further constrain the individual because there were no beneficial functional effects of intervention according to that model. Even though medical intervention could overcome the abnormality of function, there are other solutions that deliver the same outcome. When medical treatment failed to improve the function of a person with disabilities, other perspectives were needed to uncover the potential to live and avoid medically derived oppressions. Green et al., (2002) suggested that the health professional needed to add skills to reach out and communicate with patients from a perspective beyond the health sectors' constructs.

2.2.2 Medical model and physically challenged women

Within the medical model, the definition of normal is considered important in setting a standard for comparison; however, it is difficult to establish what normal is for people with disability. According to Davis (2013), normal could be defined as something that does not deviate from what is common. Disability is viewed as inferior when compared to a ‘perfect body’ that enjoys medical fitness. It can be argued that the medical perspective toward the body as normal or impaired is rooted in a social construction i.e., the patriarchal view covertly expressed within the medical field itself. Those who do not have this commonality of presentation, therefore, have aspects of themselves that need to be corrected and is considered abnormal. This standard of a normal versus an abnormal body was constructed and established by representatives of the normal group, as the dominant sector, and subsequently disseminates this biased concept of normal through the media. This view sees disability as an abnormality that needs to be hidden and/or corrected. Disability in the medical norm is measured by the medical expertise according to what is the normal standard. The problem for this measurement is when the disability is not visible. Invisible disabilities defined as an impairment that cannot be recognized through the appearance, but could hinder a person's activities due to its negative effect to the body (Ring, 2011; Taylor, 2005). Some examples of invisible disabilities include chronic pain/fatigue/dizziness, mental illness, coeliac disease, auto-immune disease, and learning disabilities (Disabled world, 2015). People with invisible disabilities experience greater challenges compared to people with visible disabilities. The challenges faced particularly is in justifying the impairment, further with the discrimination received from the healthcare worker due to the unseen impairment hard to measure and lack of knowledge of it (Ring, 2011; Taylor, 2005). With these reasons, women with invisible disabilities are prone to greater discrimination and marginalization from the healthcare professional, society, and the disability community. Studies of women with invisible disabilities are still limited. Few of the existing studies investigated the experiences of women with invisible disabilities. It recognized that invisible disabilities were not handled properly by healthcare services compared to visible disabilities (Dale, 2005; Taylor, 2005). Dale's (2005) study with 22 women with post-stroke and its sequels have a similar conclusion with a study from Taylor (2005) on 47 people (45 females, 2 male) with chronic fatigue syndromes. Both of the studies suggested that the participants received a little acknowledgement for their invisible disabilities from the disability community and the healthcare professionals. Also, they experienced difficulties in legitimising the invisible body symptoms as part of disabilities. Between 10-54 per cent of healthcare professionals would not recognize or will choose to ignore chronic fatigue syndromes as a medical problem, due to inappropriate expertise and treatment planning (Taylor, 2005). The women in both studies opine it is easier to be accepted when someone has visible disabilities rather than the hidden one. This notion is supported by the argument that disability is more associated with body parts as a visible form of physical appearance (Peuravaara, 2013). This argument seems to suggest that, people with visible disabilities receive the desired attention than those with invisible disabilities. Therefore, this study seeks to assess if there are still some challenges that women with physical or visual disabilities face in accessing skilled delivery services.

2.2.3 Social model

An alternative interpretation of disability is the social model. Supporters of this paradigm are Holmes and Dea (2012), who considered disability as natural and most likely to be encountered in everyday life, explaining that any individual is confronted with different hurdles related to disability, weakness, and dependence. This natural state encourages humans to build social relationships with one another. Thus, the social model sees disability as simply an extreme grouping within the range of normal communities, whose members are labelled as the weakest, most flawed, and most dependent. Thus, weakness, disability, and dependence are not personal characteristics of an individual entity – that of an idealized, rationalized, and atomized body per the medical model – rather this view of disability depends on the social attitudes and behaviour of the community toward the disabled person, as a sector within their own community. The position of Holmes and Dea (2012) was aligned with the Union of the Physically Impaired Against Segregation (UPIAS). Over time the ICIDH classification and implementation were considered narrow by the UPIAS in the United Kingdom (UPIAS, 1976). The Union of the Physically Impaired Against Segregation (UPIAS) claimed the social model is more appropriate, defining the differences between impairment and disability. It argues that disability was seen as a limitation to function because of external factors, acting on the person as barriers, preventing a person from undertaking certain functions and reflected on how a person interacts with and is valued by, society. It also believes that isolation, rejection, and oppression arising from disability underpinned the negative impression towards persons with disabilities (UPIAS, 1976). This view countered the limitations of the ICIDH classification, which heavily relied on the medical model (Forhan, 2009; Siminski, 2003). This movement by the UPIAS influenced the reformulation of the ICIDH definition, which was then developed and improved into the International Classification of Functioning, Disability and Health (ICF) in 2001. Even though the ICF classification is still based on health parameters, it has a broader context beyond the medical paradigm and no longer sees disability simply as a consequence of disease. Disability is now seen not only as a medical issue but also as an interaction between a person and his or her environment, and the consequences of this interaction on a person's function (UPIAS, 1976). In comparison to the medical model, the social model considers disability to be a social issue arising out of society's attitudes and the environment. Within this model, a person ought not to be labelled as being or having a disability, until it is proven that he/she is prevented from doing something (McGuire, 2012). For example, a study on autism by McGuire (2012) found that the definition of autism is a social construction as it changes according to "times", "spaces", "diagnostic criteria", "attitudes", and so on. These factors are the barriers standing between persons with autism and the environment. When the barriers are removed, the person with autism receives the opportunities to improve their lives and succeed, it means autism is non-existent. This concept is also applicable to disability when persons with disabilities are facilitated to participate and succeed; it means that this disability is not present. This concept is supported and elaborated on by Brownlee and Cureton (2009) and Rothman (2010) who agree that the environment contributes to the creation of social and cultural obstacles for persons with disabilities. Rothman's (2010) assessment of the implementation programmes stress the limitations experienced by individuals and makes efforts to accommodate persons who are disabled. For instance, if an individual has an amputated leg, this is not stigmatized, but rather accommodated with the right devices to support mobility, and via accessible building facilities such as ramps. Thus, the environment (social and physical) is modified so that an individual can function normally. Armstrong, Armstrong and Barton (2000) added that such socially disabled individuals are often hidden from the public by their families and consequently experience impeded access to schools, health, and social opportunity. This subject was identified by Gupta (2012), who noted that the disabled group is the most disadvantaged regarding employment. It can be concluded that they are the most unwanted and so will be labelled as a burden, raising a problem for persons with disabilities wherever they are in society. Despite the obvious limitations of the above position, it can be deduced from a critical analysis of the literature that the social model is seen as a more valid perspective than the medical model, even without the complication of disability (Moore, 2002; Munyi, 2012). Along similar lines, Munyi (2012) conducted a further review of the literature on disability between the years 1937 to 2002 and found societal attitudes are one of the problems raised by persons with disabilities. Attitudes are influenced by local culture and societal behaviours. He suggested that a reduction in prejudice and discrimination toward the disabled is best achieved through a coordinated program between government and disability organisations. That study added that, for such a programme to be successful, the medicalization, conformity, attitudes, and treatment of persons with disabilities must be recognised. Therefore, this model notes that society must participate in the challenges of eliminating obstacles for persons who are disabled, in order to enable them to access the environment and be independent. It can be concluded that the social model, rooted in the human rights movement, is mainly constructed to empower the individual. This proposition implies that every person has fundamental rights that must be facilitated by the government (Combrinck & Reenen, 2012). Shakespeare and Watson (2001) stress one key fact of the social model – this perspective recognises that the solution lies in social deconstruction or total societal transformation. This strategy seeks to remedy through the removal of barriers being experienced by disabled persons, whether such barriers are physical or attitudinal. The literature has emphasized that both state and society need to be aware of the significant influence of existing social constructions and the negative effects they can have on the standing of the person with disabilities, in society (Barnes & Mercer, 2010; Davis, 2013). Schaaf (2011) built on these arguments by stating that social perspectives see disability as an issue that arises from social pressures. A distinction has therefore been made between impairment and disability. Disability is an incapacity construed by social constraints, whereas impairment is a physical or mental dysfunction or disadvantage (Schaaf, 2011).

However, the social model's attention to physical and environmental barriers has often failed to accommodate social factors beyond disabilities, such as gender, ethnicity, and social status. It also neglected the subjective experiences of an individual from a medical point of view (Shakespeare & Watson, 2001). Despite the growing support for the social model, disability still does require medical treatment to help manage it. It needs to be highlighted that perspectives on disability are not limited only to medical and social perspectives. Each of the models has been developed with variations, contributing to the understanding of the complexity of disability. Other perspectives such as the charity model, the economic model, the empowerment model, the religious model, the social adapted model, and the comprehensive bio-psychosocial model (WHO, 2005) are employed according to need.

Based on existing regulation and programs, the Ghanaian policy-maker still adheres to the medical and charity model, reflected in their decision that created a hierarchical social construction composed of the donor and the recipient groups. The donor group is the giver, and the beneficiary is the person with disabilities. This construction is believed to be the best way to aid the unfortunate situation of disability and assist to compensate for the imperfection. The attitudinal and environmental barriers related to disability create social exclusion and disadvantages. The social model offers a positive breakthrough through its attention to the social and environmental barriers achieving the inclusion of people with disabilities in the process. Thus, the social model presumes to remove the barriers caused by disability and to help the person with disabilities to have a normal life. These deliberations will be useful when considering how expressions of the social model are taken into account when defining an accommodating and responsive health policy. Disability is a compounding effect produced by a combination of the impairment and environment and if the two contributory factors are eliminated, it would not mean disability would be resolved. Outside of impairment and disability is where the solution lies. Factors such as societal and cultural hold a broad spectrum of policy and widely differing opinions on the definitions of barriers for persons with disabilities, and the implications of those barriers on individuals. Both the social and medical models have been relevant and convincing during their eras, but neither can accommodate the complexity of, and the wide-range of, problems experienced within disability.

2.2.4 Social model and physically challenged women

The social model proposes that social construction is the cause of the marginalisation and oppression of physically challenged women. They are facing negative attitudes in the form of segregation from society, stigmatisation, discrimination, and punishment depending on the norms, cultures, and beliefs of the society. This behaviour, coming from private and public domains, relates to social role theory that expounds this point of view and the consequent abuses. Additionally, in developing countries, the right support from respective government agencies is still difficult to find (WHO, 2005). The combination of their vulnerable position as women and the stigma of disabilities, plus the lack of support from government agencies causes physically challenged women to be unheard and marginalized (Puri et al., 2015). The social model through a feminist perspective recognizes disablement and gender oppression toward physically challenged women is a part of common practice from a healthcare professional (Kirch, 2008). In the medical field, social construction sees the able-body as normal, thus, when healthcare professional faces physically challenged women as patients, their attitude in treating the patients' influenced by disabilities or gender factors, rather than a single entity (Peuravaara, 2013). Lack of knowledge from the health care worker could fail the problems identification, as medical and social issues need different approaches. Hladki (2008) suggested that in order to be heard, physically challenged women have an obligation to act. Hladki (2008) stated that disabled peoples themselves are responsible for correcting discrimination through appropriate attitudes in order to overcome their situation and in order to achieve improved conditions - that the solution is within the power of the individual with the disability and how they interact with society. On the other hand, there is an alternative proposition that disability is a social construction. Societal constructs are expressed through social control, resulting in physically challenged women being marginalized and denied expression. Therefore, the view that the responsibility is in the hands of individuals with disabilities is untenable. Society and culture itself must change.

There is also a debate about whether the social construction of women and disability can be separated. Society sees women and disability as two different matters, each of which requires special handling in an attempt to escape from under the heavy hand of discrimination. As Groce (1997) observed, not many studies have been conducted on the life of physically challenged women, so little is understood of the difficulties experienced or the factors involved. Begum (1992) has proposed a related line of thought within the development of divisive identities within the broader category of disability. Disabilities are seen as integral to physically challenged women; the woman and her disabilities are inseparable. Thus entwined, Begum (1992) purported that problems need to be solved through a comprehensive focus on the everyday realities faced by physically challenged women. Feminist scholars propose to raise the dignity of physically challenged women in society by ending discrimination; raising public awareness of injustices and reshaping and restructuring society. Discrimination, faced by physically challenged women, informs an important component of health policy. Angelides (2012) defines discrimination as all acts that distinguish between individuals or groups that benefit one party while harming the other party. Based on this definition, if an action helps persons with disabilities to be able to walk while non-disabled persons do not have the same assistance, this is not discriminatory but enabling. When such help assists persons with disabilities to participate in work or other activities, this support also benefits the non-disabled population to join the participation. Such interventions benefit both parties. Morris (1989) noted that discrimination towards physically challenged women may arise from judgments regarding their physical appearance, which immediately renders an opinion based on social conformity. Without public acceptance, the disabled population will not be able to voice their opinions. And without the disabled population expressing their opinions, people will not understand the inside world of physically challenged women. Moreover, because disability is very diverse, people with disabilities can be considered as separate groups and their collective voice further weakened. This study, therefore, seeks to be grounded on the Interpretative phenomenological analysis (Smith & Osborn, 2003) that will allow the participants to openly express their opinions for us to understand the inside world of their disabilities and the challenged they face and how these challenges could be removed.

2.2.5 The Human Rights Model

The Human Rights Model can be seen as the most recent development of the Social Model. It states that, all human beings are equal and have rights that should be respected without distinction of any kind, also, people with disabilities are citizens and, as such, have the same rights as those without impairments and lastly, all actions to support people with disabilities should be "rights based", for example, the demand for equal access to services and opportunities as a human right (Digital Campus, n.d.). Like the Social Model, the Human Rights Model places responsibility for addressing the problems of disability on society rather than on the person with disabilities. It also places responsibility on one to ensure that appropriate legislation designed by the government is complied with at a local level.

2.2.6 The Capability Model

The Capability Model developed by A.K. Sen is a useful framework for defining disability as it attempts to understand its economic causes and consequences (Mitra, 2006). Disability is understood as a deprivation in terms of capabilities or functioning. This results from the interaction of an individual's personal characteristics (e.g., age and impairment) and a collection of available goods (assets and income) and environmental factors (social, economic, political and cultural). In relation to the level of personal characteristics, impairment rather than disability is used. When it comes to capabilities and functioning, deprivation is the result of the interaction among the resources available to the person, personal characteristics and the environment. Disability is the result of an individual's deprivation of practical opportunities as a result of impairment. Under the Capability Model, disability may be analysed on two separate levels, as a deprivation of capabilities (potential disability) or as a deprivation of functioning (actual disability). Understanding the economic burden and environment of disability is part of understanding disability (Mitra, 2006). The capability framework allows us to understand that poverty and disability affect one another in a circular relationship (Braithwaite & Mont, 2009).

2.3 Disability prevalence

Partly because of the methodological challenges discussed above, reported disability prevalence rates to vary widely. Censuses and surveys globally take very different approaches to measure disability and have faced methodological issues for decades giving reasons for concern regarding measured prevalence rates (Krahn et al., 2015; Molden & Tøssebro, 2012). In fact, the same country can record very different rates of disability with different instruments (Mont, 2007).

The number of people in the world with disabilities is growing. WHO and the World Bank jointly produced the first world report on disability. This report suggests that over a billion people globally today experience some form of disability. According to the WHO (2011), about 15% of the world's population lives with some form of disability – of whom 2-4% experience significant difficulties in functioning. This prevalence is higher than previous estimates of 10% dating back to the 1970s. This global estimate for disability, according to WHO, is on the rise due to the ageing population, the increase in chronic diseases, as well as improvements in the methods used to measure disability. The vast majority of people living with disabilities live in low-income countries and most of them are very poor (MacLachlan & Swartz, 2009).

2.4: Disability in Ghana

Data from Ghana's 2010 Population and Housing Census suggest that some 737,743 (3% of the population) persons were living with disability in Ghana (Persons with Disability Act of Ghana (Act 715). However, other recent estimates suggest

Ghana's disability rate between 7–12%, approximately 1.55–2.2 million people (WHO and World Bank, 2011). A total of 64% of Ghanaian adults with disabilities are women (Tuakli-Wosomu & Haig, 2014). The disability prevalence rate among women and men is 10.6% and 6.2% respectively (Tuakli-Wosomu & Haig, 2014). The three most prevalent types of disability are those related to physical disabilities, visual impairment, and hearing impairment (WHO & World Bank, 2011).

Ghana is a signatory to the United Nations' Convention on the Rights of Persons with Disabilities, and in furtherance of this, Ghana enacted the Persons with Disability Act (Act 715) in 2006 (Persons with Disability Act of Ghana (Act 715). While widespread implementation and enforcement of the act is yet to be reported, the Act guarantees persons with disability the right to access the same or specialised range, quality and standard of healthcare as provided to other persons, including those in the area of sexual and reproductive health (Ghana Statistical Service, 2012). The Act enjoins Ghana's Ministry of Health to make provisions for free general and specialist medical care, rehabilitative treatment and appropriate assistive services for persons with disability (Persons with Disability Act of Ghana (Act 715). The Act also mandates Ghana's Ministry of Health to include the study of disability and related issues in the curricula of training institutions for health professionals to develop appropriate human resources to provide general and specialised rehabilitation services (Persons with Disability Act of Ghana (Act 715). Other relevant provisions include access to public places and services as well as the integration of the needs of persons with disability into the design, construction and operation of transport network (Persons with Disability Act of Ghana (Act 715). Access to healthcare generally refers to one's ability to receive the needed treatment. Access to healthcare is an important determinant of equity in health care delivery (Reynolds, 2010). Facilitating access concerns helping people to command appropriate health care resources in order to preserve or improve their health.

The United Nation's Convention on the Rights of Persons with Disabilities (UNCRPD) is a human rights instrument on an international level intended to protect persons with disabilities' dignity and rights. Promotion, protection and insurance of the full enjoyment of human rights by persons with disabilities, as well as full equality under the law, is what the convention sets out (United Nations, 2008).

There are eight guiding principles that underlie the Convention:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities (United Nations, 2008).

Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of these services, and the opportunity to obtain the services exists, then a population may ‘have access’ to services (Guliford, 2002). The extent to which a population ‘gain access’ also depends on financial, organizational and social or cultural barriers that limit the utilization of the services. Reynolds (2010) also observed that geographical, financial and transportation factors influence access to health care. Andersson, (2010) states that religious and cultural norms are the two main variables that influence perceptions about disability in Ghana, also many societies in Ghana perceive disability as the result of a curse, witchcraft, magic or sorcery. In some instances, it is viewed as a punishment for previous sins committed by persons with disabilities or close relatives (Andersson, 2010). In some cultures, persons with disabilities are hidden and may even be killed (Andersson, 2010). The stigma associated with disability make the condition undesirable and prevents many families from accessing healthcare.

Andersson (2010) identified three factors responsible for the generally negative perception of disability among Ghanaians. The first has to do with physical wholeness and attractiveness. The second view associates disability with lower economic status and this is reinforced by sights of numerous persons with disabilities begging for alms on the streets. The third notion associates disability with a metaphysical order and this notion usually portray persons with disabilities as beings linked to divine favour so that acts of kindness to persons with disabilities is reciprocated by divine fortunes. Thus a vicious cycle sets in, in which disabled persons representing a marginalized group receive alms from other members of the society, who in turn expect some divine favours, reinforcing some of the aforementioned negative perceptions. These ways of conceptualizing disability have restricted the participation of disabled persons in their access to healthcare, social, cultural, economic and political activities in general. Geographical access involves the spatial interactions of people and health facilities Financial access refers to the ability of people to demand and pay for health services when the need arises. Transportation access refers to the extent to which people can get to health facilities. Thus, access measured in terms of utilization is dependent on the affordability, physical accessibility and acceptability of services, and not merely adequacy of supply. Services available must also be relevant and effective if the population is to 'gain' access to satisfactory health outcomes. Finally, the availability of services should be complemented by the absence of barriers that may act to limit access (Andersson, 2010).

2.5 Skilled delivery and maternal health in Ghana

Childbirth is a reproductive right of every woman in their reproductive age and it is very essential for human existence. However, complications that may occur during childbirth can lead to death or disability of a mother or a child (Combrinck & Reenen, 2012). Skilled delivery is one of the services rendered as part of safe motherhood campaign to prevent maternal and infant deaths. Since 2004, WHO advocates for skilled care at every birth. Thus every woman in labour must be attended to or supervised by a skilled attendant who has been trained to provide quality services to mothers and babies during childbirth. Ensuring quality maternal care services can save the lives of women and newborns.

According to United Nations (2015), a woman dies from complications in childbirth every minute and about 529,000 each year and the greater majority of these deaths are in developing countries of which Ghana is not an exception. The direct causes of maternal deaths outlined by UNICEF are hemorrhage, infection, obstructed labour, hypertensive disorders in pregnancy, and complications of unsafe abortion. In Ghana, maternal mortality ratio is still on the increase and remains at an alarming rate of 320/100,000 live births in 2011, 324/100,000 live birth in 2012, 321/100,000 live birth in 2013, 322/100,000 live birth in 2014 and 319/100,000 live birth in 2015 (WHO, 2015). The statistics above indicate that Ghana has failed to meet the MDG 5 target of 185 maternal deaths per 100,000 by 2015. An estimated 2,700 mothers' life could be saved every year with access to safe clinics and skilled care (WHO et al., 2012). A woman in Ghana has (1 in 68) lifetime risk of dying from a maternal cause during childbirth (WHO, 2011).

In Ghana, 63 newborns die every day during childbirth which could have been saved through skilled delivery (United Nations, 2015). The government of Ghana has since 2005 introduced free maternal health policy that makes maternal health services free of charge in all health institutions. Furthermore, the introduction of a National Health Insurance Scheme in all districts in Ghana was expected to reduce the financial burden on pregnant women in order to increase access to skilled birth care services (GHS Report, 2007). However, these interventions by the government of Ghana have not yielded the needed results. The antenatal (ANC) coverage in Ghana was 97% and skilled delivery was 74% in 2014 (GDHS, 2014). In the Northern region, skilled delivery was 53.3% in 2014 and 52.8% in 2015 (GHS Report, 2015). Large and growing gradients of inequalities in skilled care services accessibility and utilisation have been observed in Ghana (Ganle et al., 2014).

2.6 Access to health care by people with disabilities

Access to health care is a major health and development issue (Combrinck & Reenen, 2012) and plays a major role in the performance of health care systems globally (Levesque et al., 2013). It is an important concept in the study of the organisation, financing and delivery of health care services (Ricketts & Goldsmith, 2005). While the literature on access to health care is large, diverse and complex (Dixon-Woods et al., 2006), there are no global criteria on how to define and measure access (Oliver & Mossialas, 2004). Racher and Vollman (2002) mention how access as a concept was “nebulous and obscure” to most of the public as well as policymakers and practitioners while Combrinck and Reenen (2012) state that equitable access “remains an empty formula” for politicians and experts.

Despite the focus and attention that is placed on access to health care services, it is surprising that there is still a degree of ambiguity in defining access (Sibley & Weiner, 2011). A review of the literature reveals diverse uses of the word ”access” (Norris & Aiken, 2006) while the conceptualisation and operationalisation of the term are not consistent (Dixon-Woods et al., 2006; Gulzar, 1999; Levesque et al., 2013). It is not a simple undifferentiated category (Heap et al., 2009). Access to health services is a complex concept (Guillford et al., 2002; Hjortsberg & Mwikisa, 2002; Levesque et al., 2013), it is difficult to define (Al-Taiar et al., 2010) and there are hence many definitions (Peters et al., 2008). The concept of access to health care has become somewhat of a “catch-all” phrase, and the meaning varies significantly with whoever uses it (Norris & Aiken, 2006). As Karamitri et al. (2013) state, accessibility to health services is a “complex and multifaceted” issue with researchers exploring accessibility from different points of view. Access to health care incorporates “a variety of nuanced definitions” (Meade et al., 2015). It is a multidimensional concept (Cabieses & Bird, 2014; Nemati et al., 2014). For example, to analyse access to health care one may consider the narrow domain – from the moment the patient seeks care to the moment attention is first received – or the broad domain – from perceiving the need for health care through to the use of services, including all contact throughout the episode (Garcia-Subirats et al., 2014). Some have extended the latter to include satisfaction with care received and incorporate aspects of quality and health outcomes (Anderson, 1995). However, according to Garcia-Subirats et al. (2014), most studies on access to health care tend to focus on initial contact and on a specific type of barriers related to the services or the population. To come up with a comprehensive definition of access has been a problem. Although there have been attempts in the past to clarify its complexities, access to health care has remained a rather vague concept, thus preventing the work of health care policymakers and professionals in making meaningful health care reform (Brownlee & Cureton, 2009). The components or aspects of access to health care are not very well understood (Gulzar, 1999). Being able to access health care raises issues about the meaning and measurement of access to health care (Guillford et al., 2002).

A highly cited contribution to the effort to define and measure access to health care is the work of Penchansky and Thomas (1981), published over thirty years ago. They proposed that the specific areas, the dimensions of access, are as follows:

1. **Availability:** the relationship of the volume and type of existing services (and resources) to the clients’ volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers; of facilities such as clinics and

hospitals; and of specialised programmes and services such as mental health and emergency care.

2. **Accessibility:** the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost.
3. **Accommodation:** the relationship between the manner in which the supply resources are organised to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness.
4. **Affordability:** the relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance. Client perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements.
5. **Acceptability:** the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. In the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, a neighbourhood of a facility, or religious affiliation of facility or provider. In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e.g., welfare patients) or, through accommodation, make themselves more or less available.

Following the work of Penchansky and Thomas, Guillford et al. (2002) claim access is a multi-dimensional concept that should be measured on at least four dimensions: Service availability, Utilisation of services and barriers to access including personal, financial and organisational barriers, Relevance and effectiveness, and Equity. Likewise, Peters et al. (2008) argue that access is a multidimensional process that includes quality of care, geographical accessibility, availability of the right type of care for those who need it, financial accessibility, and acceptability of service. Their conceptual framework for assessing access to health services is as follows:

1. **Geographic accessibility** – the physical distance or travel time from service delivery point to the user;
2. **Availability –** having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials;
3. **Financial accessibility –** the relationship between the price of services (in part affected by their costs) and the willingness and ability of users to pay for those services, as well as be protected from the economic consequences of health costs;
4. **Acceptability –** the match between how responsive health service providers are to the social and cultural expectations of individual users and communities.

This final element is perhaps the least well developed but one of the most important. We need to understand that there are different kinds of barriers when accessing health care. For example, Lagu et al. (2014) state that barriers to access are the result of a variety of physical, policy, procedural and attitudinal factors and “we need to begin to characterise these barriers and identify domains (or axes)” that will help improve and achieve access to health care. Some of these barriers overlap with one another and have been referred to interchangeably by different authors. The literature on access to health care includes reference to physical barriers (Iezzoni et al., 2010; O'Day et al., 2002), programmatic barriers (Yee & Breslin, 2010), structural barriers (Hwang et al., 2009; McColl, 2005), procedural barriers (Hwang et al., 2009), physician barriers (Harrington et al., 2009; O'Day et al., 2002), environmental barriers (Kroll et al., 2006), process barriers (Kroll et al., 2006) and financial barriers (Callahan & Cooper, 2006; Krahn et al., 2006; O'Day et al., 2002; Sommers, 2006). These barriers can occur in isolation or, more commonly, in an interaction with one another.

In summary, research on access to health care has been done widely for several years within many countries including using various methodological approaches and disciplines, but definitions vary significantly across populations depending on broad social, economic and cultural components (Cabieses & Bird, 2014).

2.7 Perception of physically challenged women about skilled delivery

Perception is the process by which people interpret and organize sensations in order to produce a meaningful experience of the world. In other words, when a person is confronted with a situation or stimuli, the person interprets the stimuli into something meaningful to him or her based on prior experiences. However, what an individual interprets or perceives may be substantially different from reality (Combrinck & Reenen, 2012). A review of literature relating to attitudes and perceptions of persons with disabilities towards skilled delivery indicates a majority of persons with disabilities are of the opinion that nurses and midwives are not versed with sufficient experience, nor requisite skills and knowledge of how to handle physically challenged women. Indeed, they do not only complain about a lack of technical knowledge but also about their unhelpful attitude (Gulliford et al., 2002). Other researchers have shown that many service providers have little experience of disabled people's needs (Morrison et al., 2014).

physically challenged women perception of health facilities quality are ultimately hinged on the interaction they have with nurses at these service providers and must, therefore, ensure that every service encounter will positively influence the customers' evaluation of the facility experience (West et al., 2007). This has significant economic benefits for the industry when one considers it has been verified through research, that physically challenged women are more loyal to establishments which meet their needs than persons without disabilities (Gulliford et al., 2002). Research has affirmed that training is a key avenue through which a change in the attitudes of persons without disabilities towards those with disabilities can be effected (Morrison et al., 2014). In response to this key fact, many service providers have instituted disability training for their staff to mitigate this apparent weakness (West et al., 2007). The effectiveness of these training programs has however been questioned. It has been claimed that even for health facilities that conduct disability awareness training; the training is not producing the desired outcome of ensuring positive skilled delivery experiences. The authors thus suggest that health facilities should re-evaluate and possibly expand their sensitivity training programs (Gulliford et al., 2002).

Research has also established that educational institutions in the field of health have also contributed to the situation of not preparing staff adequately to handle persons with disabilities at the place of work. It has indeed been noted that, even as health sector courses content develop, there appears to be very little consideration of the accommodation of the needs of physically challenged women in the course training curriculum for staff pertaining disability awareness (West et al., 2007). The role of involvement of physically challenged women and disability organizations in looking out for the need of physically challenged women and rating of facilities for the health sector has started generating some considerable attention from disability researchers (Gulliford et al., 2002). The collaboration of disability organisations and the health industry in championing for improved products and services for physically challenged women cannot be under emphasised (Morrison et al., 2014). Gulliford et al. (2010) suggest that by consulting physically challenged women, staff can go “above and beyond” the requirements of the skilled delivery for physically challenged women. Research by Al-Taiar et al. (2010) revealed that physically challenged women trust these organisations (have a positive attitude towards them) and are concerned with who collected the information. At the moment we don’t have such kind of organizations liaising with the Ghana industry in Ghana to improve the situation of physically challenged women.

Empirical research has also indicated that physically challenged women exhibit positive

attitudes towards health facilities that portray them positively in their promotional material. Research by Fonow and Cook (2005), suggested that health care providers can easily reach out to physically challenged women by simply including a person in a wheel-chair or a deaf person signing (as well as those with other disabilities) in their line of work. They further noted that physically challenged women often remember when they have been appreciated and made to fill part have a more positive attitude toward those organizations that practice inclusion (Fonow & Cook, 2005). Several studies have addressed the experiences of persons with physically challenged women in medical situations. Interpersonal interactions between hearing health care providers and physically challenged women patients may be difficult if the health care provider does not understand the rules and behaviours of disabilities culture. For example, the providers may be perceived as impolite if they do not maintain focus when caring for a disabled woman. Many health care providers also do not understand that many persons with disabilities feel marginalised once they are deformed in one way or the other. Historically, persons with disabilities had been viewed negatively and were thought to be inadequate and inferior persons (West et al., 2007). This can increase the likelihood for physically challenged women not to ask for clarification so that they do not appear stupid. Reynolds (2010) used focus group discussions in three U.S. cities to research persons with disabilities health care experiences. Participants in the focus groups said that they cared best when “medically experienced” were provided, but that these were “infrequently available.” Themes that emerged from the focus groups included disabled persons skewed understanding of the health care provider’s instructions and their sense of fear in medical settings. The latter included both a fear of the consequences of miscommunication and a fear of letting health care providers know that the communication was inadequate. Likewise, participants were fearful of changing doctors, as a new doctor might be reluctant to pay attention to their disabilities. Participants also reported a sense of mistrust and a feeling that some providers disliked working with persons with disabilities. The authors of the study concluded that persons with disabilities, infrequent contact with healthcare providers who know their history and culture, and the frequent necessity of using family and friends as assistants (Clancy & Andresen, 2002).

In another study, Reynolds (2010) interviewed 45 physically challenged women on their perceptions of access to health care. These women exhibited a lack of knowledge of health issues and reported negative health care experiences and insensitive behaviours on the part of providers. They tended to avoid health services because of previous negative experiences. The authors recommended the development of special resource materials improved prevention strategies targeted specifically to persons with disabilities, and the development of self-advocacy skills among the physically challenged women population. The women in these studies also expressed frustration at the difficulty of scheduling services, and the subsequent delays this caused.

Group interviews in Boston amongst persons with disabilities found providers' conflicting assumptions about disabilities to be a major source of distress in medical encounters (Iezzoni et al., 2010). Physicians often questioned disabilities patients about the cause of their disabilities despite the fact that it was unrelated to the health problem that had brought them to the office. Participants felt that some medical doctors did not respect their "intelligence, motivation, and desire to understand and participate in their health care" (Iezzoni et al., 2010). They reported that doctors often did not understand that providing health care was the responsibility of the health care provider. Doctors were also unaware of the need to have doctors who have the experience and knowledge in medical settings attend to physically challenged women. Another issue in the disagreement with providers involved time. physically challenged women patients typically expressed the need for more time than their clinicians could or would provide.

2.8 Challenges faced by women with disability in accessing health services

Though there is no consistency amongst disability researchers about what might constitute the greatest challenge facing persons with disabilities, some researchers postulate that negative staff attitudes are the greatest limiting barriers (Brownlee & Cureton, 2009). Other researchers advance the preposition that societal attitudes towards persons with disabilities are the most potent and negative stressor in their lives (Andersson, 2010), while others identify the aspect of health care provision (Clancy & Andresen, 2002). What however seems to have the largest number of proponents is the issue of accessing information prior to departure (Al-Taiar et al., 2010) with some disability researchers noting that lack of accessing trustworthy and quality information to be perhaps the greatest challenge facing persons with disabilities (Gulliford et al., 2002).

Four significant accessibility barriers put persons with disabilities at a significant disadvantage: knowledge, transportation, financing and communication barriers (Gulliford et al., 2002). Access to skilled delivery can lead to exclusion of physically challenged women from health services or lead physically challenged women to delay in seeking health care. Lack of knowledge on health-related issues often makes persons with disabilities less assertive in seeking specific services because they usually are lost as to where to go to access that specialized service while the lack of funds may make it difficult for physically challenged women to seek for more expensive specialized health care from a specialist even if they are able to locate the specialized services. Difficulties with transportation often emanate from lack of funds to board public means and the difficulties of physically challenged women driving (Andersson, 2010).

2.9 Theoretical framework

Interpretative phenomenological analysis (Smith & Osborn, 2003) is the possible theory that meets the aim of this study in that it focuses on exploring and categorizing phenomena while retaining the integrity of the original data. The primary goal of Interpretative Phenomenological Analysis (IPA) is that the researchers investigate how individuals make sense of their experiences. It is assumed that people are 'self-interpreting beings' (Taylor, 1985), which means that they are actively engaged in interpreting the events, objects, and people in their lives. The phenomenological approach to the body fits well with the empirical investigation of the lived experience of disabled women. In this case, the body is approached as a subject, rather than as an object shaped exclusively by external discourses. For instance, the ways disabled women articulate, interpret, and experience the disability and the relation between body and self (i.e. body and mind), as well as the examination of the cultural resources disable women draw upon to make sense of their experiences, can provide useful insights on how the disabled woman experience or live in a particular geographical, socio-cultural, and temporal context.

IPA's theoretical underpinnings stem from phenomenology which originated with Edmund Husserl's attempts to construct a philosophical science of consciousness, with hermeneutics (the theory of interpretation), and with symbolic interactionism, which posits that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process (Husserl, 1999). Phenomenological studies will thus focus on how people perceive and talk about objects and events, rather than describing phenomena according to a predetermined categorical system, conceptual and scientific criteria. This study will, therefore, focus on how disabled women perceive and talk about access to skilled delivery. This involves 'bracketing' one's preconceptions and allowing phenomena to speak for themselves. Bracketing is a methodological device of phenomenological enquiry that requires deliberate putting aside one's own belief about the phenomenon under investigation or what one already knows about the subject prior to and throughout the phenomenological investigation (Carpenter, 2007).

The Second theoretical orientation which Phenomenological Analysis relies upon is Hermeneutics. According to hermeneutics (from the Greek word '*to interpret'* or '*to make clear'*), one needs to comprehend the mindset of a person and language which mediates one's experiences of the world, in order to translate his or her message (Freeman et al., 2008). Thus, this research will attempt to understand what it is like to stand in the shoes of the subject (although recognizing this is never completely possible) and through interpretative activity make meaning comprehensible by translating it. The analytical process in IPA is often described in terms of a *double hermeneutic* or dual interpretation process, because firstly, the participants make meaning of their world and secondly, the researcher tries to decode that meaning - make sense of the participants' meaning-making (Smith & Osborn, 2003). In other words, this research will try to understand what childbirth is like from the participant's perspective, the unique experiences and how they are delivered. To sum up, IPA synthesizes ideas from phenomenology and hermeneutics resulting in a method which is descriptive because it is concerned with how things appear and letting things speak for themselves, and interpretative because it recognizes there is no such thing as an un-interpreted phenomenon.

The third theoretical orientation which Phenomenological Analysis (PA) relies upon is idiography. It refers to an in-depth analysis of single cases and examining individual perspectives of study participants, in their unique contexts. The fundamental principle behind the idiographic approach is to explore every single case, before producing any general statements. IPA relies on idiography, meaning that researchers focus on the particular rather the universal (Smith et al., 1995). This research will make specific statements about study participants because the analysis will be based upon a detailed case exploration. This research will thus start with examining an individual and producing a case study or will move to an equally attentive exploration of the second case, and so on.

CHAPTER THREE

METHODOLOGY

3.1: Study area

The study was conducted in the Tamale Metropolis. Tamale Metropolitan Assembly was established by legislative instrument (LI, 2068) which elevated the then Municipal Assembly into a Metropolis in 2004. At present, it is one of the six Metropolitan Assemblies in the country and the only Metropolis in the five Northern regions namely: Northern, Upper East, Upper West, Savanna, and North East regions. It has Tamale as the Metropolitan capital city and at the same time the regional capital of the Northern Region (Ghana Statistical Service, 2012).

3.1.1 Location, Size and Physical Features

The Tamale Metropolis is located in the central part of the Region and shares boundaries with the Sagnarigu District to the west and north, Mion District to the east, East Gonja to the south and Central Gonja to the south-west. The Metropolis has a total estimated land size of 646.90180 sqkm (Ghana Statistical Service, 2012). Geographically, the Metropolis lies between latitude 9º16 and 9º 34 North and longitudes 0º 36 and 0º 57 West. Tamale is strategically located in the Northern Region and by this strategic location, the Metropolis has a market potential for local goods from the agricultural and commerce sectors from the other districts in the region. Besides the comparative location of the Metropolis within the region, the area stands to gain from markets within the West African region from countries such as Burkina Faso, Niger, Mali and the northern part of Togo and also en-route through the area to the southern part of Ghana (Ghana Statistical Service, 2012).

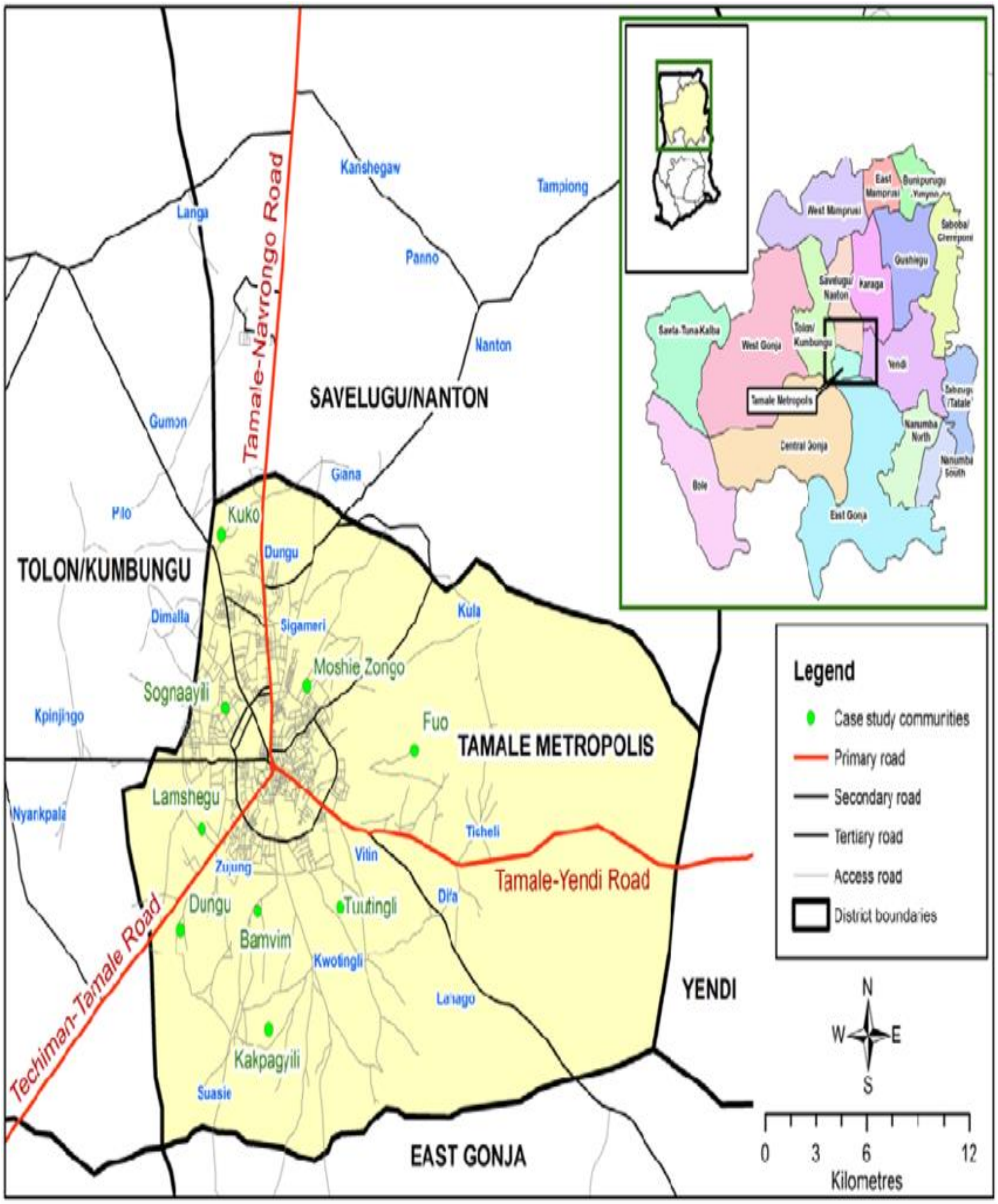

Figure 3.1 Map of Tamale Metropolis **Source: GSS, 2012**

3.1.2 Population size, structure and composition

The population of Tamale Metropolis, according to the 2010 Population and Housing Census, is 233,252 representing 9.4% of the region's population. Males constitute 49.7% and females represent 50.3%. The proportion of the population living in urban localities (80.8%) is higher than that living in rural localities (19.1%) of the metropolis. The metropolis has a sex ratio of 99.1. The population of the metropolis is youthful (almost 36.4% of the population is below 15 years) depicting a broad base population pyramid which tapers off with a small number of elderly persons (60 years and older) representing 5.1 %. The total age dependency ratio for the district is 69.4, the age dependency ratio for rural localities is higher (86.5) than that of urban localities (65.7) (Ghana Statistical Service, 2012).

3.1.3 Household Size, composition and structure

The metropolis has a total of 219,971 households. The average household size in the metropolis is 6.3 persons per household. Children constitute the largest proportion of the household structure accounting for 40.4% and heads of household make-up 16.1% of the household population. Spouses form about 9.4% and other relatives constitute 12.9% of the population. The proportion of households who live in extended household structure (head, spouse (s), children and head's relatives) constitute the largest proportion (46.1%) than that of any other type of household structure. Nuclear households (head, spouse (s) and children) constitute only 19.5% of households in the metropolis (Ghana Statistical Service, 2012).

3.1.4 Economic Activity Status

About 63.3% of the population aged 15 years and older in the metropolis is economically active and 36.7% are economically not active. Of the economically active population, 92.6% are employed while 7.4% are unemployed. For those who are economically not active, a larger percentage of them are students (56.0%), 20.9% perform household duties and 12.4% are either too young or old to work. About five out of ten (52.9) of unemployed persons in the metropolis are seeking work for the first time (Ghana Statistical Service, 2012).

3.1.5 Social and Cultural Structure

Historically, the Northern Regions of the country had a vast land cover with smaller population sizes and the Metropolis is of no exception. This area begun experiencing high population growth after many people with different ethnic backgrounds started migrating from other areas to settle there, thus, making it a cosmopolitan area. The Dagombas are the majority and other ethnic groups such as Gonjas, Mamprusis, Akan, Dagaabas and groups from the Upper East Region are also residing in the Metropolis. Also found in the Metropolis are other nationals from Africa and other countries across the globe. The area has deep-rooted cultural practices reflected in activities such as annual festivals, naming and marriage ceremonies. Some of the festivals that are celebrated annually in the Metropolis are Damba, Bugum (fire festival) and the two Muslim Eid festivals (Eid Fitr and Eid Adha) and the Christians festivals such as (Christmas & Easter). The Metropolis is dominated by Muslims and followed by Christians, spiritualists and traditionalists (Ghana Statistical Service, 2012).

3.1.6 Health facilities and Educational institutions

The Tamale Metropolis has a number of health facilities including private Medical Diagnostic and Laboratory centres. The prominent health facilities in the metropolis include; the Tamale Teaching Hospital, the Tamale Central Hospital, The Moshie Zongo Clinic, The Tamale West Hospital, Seventh Day Adventist Hospital (SDA), JAG's Clinical Laboratory Limited and Kabsad Scientific Hospital, among others. There are a good number of both private and government schools comprising Secondary, Junior, Primary and Kindergarten Schools in the metropolis. Of the population, 60.1% are literates and 39.9% are non-literates. The proportion of literate males (69.2%) is higher than that of females (51.1%) (Ghana Statistical Service, 2012). There are also reported cases of liver-related diseases such as liver cirrhosis, elevated cholesterol, diabetes, sexual weakness, hypertension, PIH, and hepatitis among others in the Tamale Metropolis and Ghana as a whole (Ghana Statistical Service, 2012).

3.1.7 Fertility, mortality and migration

The Total Fertility Rate for the metropolis (2.8) is slightly lower, compared to the regional fertility rate of 3.5. The General Fertility Rate is 79.9 births per 1000 women aged 15-49 years. The Crude Birth Rate (CBR) is 21.2 per 1000 population. The crude death rate for the metropolis is 5.6 deaths per 1000. Accident/violence/homicide/suicide accounts for 9.6% of all deaths while other causes contribute to 90.5% of deaths. Majority of migrants (54.9%) living in the metropolis were born elsewhere in the region while 45.1% were born elsewhere in another region. For migrants born elsewhere in another region, those born in Northern region have the highest proportion (19.6%) followed by those who were born in the Upper East (18.7) (Ghana Statistical Service, 2012).

3.1.8 Occupation

Occupation is defined as the type of work a person is engaged in at the establishment where he/she works. This was asked of persons 5 years or older who worked in the last 7 days before the census night, and those who did not work but had a job to return to as well as those unemployed who had worked before. All persons who worked during the 7 days before the census night are classified by the kind of work they are engaged in. The emphasis was on the work the person did during the reference period and not what he/she is trained to do.

The occupation with the highest population in the Metropolis is service and sales workers (33.0%). This is followed by those in the craft and related trades works (21.5%). The proportion of the employed persons engaged in skilled agricultural forestry and fishery is 17.6%, which is the third-largest occupation in the metropolis. There are more males compared to females in almost all the occupations with the exception of service and sales where only 16.5% of males are engaged, compared to a large proportion of 50.3% for females. Also, there are more females (11.3%) than males (6.1%) in the elementary occupation category (Ghana Statistical Service, 2012).

3.1.9 Transport

The major transport services in the area are taxi cabs with the main taxi station in the Central Business District (CBD). State Transport Company, Metro Mass Transit, O. A. Travel and Tours and other private bus services link the Metropolis with other cities and towns in the country. Most of the people also use motorbikes as their means of transport within the Metropolis. For easy transport of goods and services, EMS, FEDEX, DHL and others offer fast and reliable express services from the Metropolis to other places (Ghana Statistical Service, 2012).

3.2 Study design

A research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. This was an explorative qualitative study with a phenomenological approach using in-depth qualitative interviews. In general, qualitative researchers provide a systematic approach for describing individuals' experiences and in fact give meaning to these experiences (Polit & Beck, 2006). Researching a sensitive issue needs a careful selection of methodology. Qualitative methodology is most often chosen by researchers (Chirawatkul & Manderson, 1994; Warr, 2004) who undertake research in sensitive issues due to its strength in providing rich textual descriptions of people's experiences in any given situation. The qualitative methodology may also help a researcher to identify the contradictory behaviours, beliefs, opinions, and emotions from the participant's perspective (Punch, 1998).

According to Rice and Manderson (1996), qualitative research's flexibility helps the researcher to understand meanings, interpretations and subjective experiences of vulnerable groups. In addition, qualitative research methods allow researchers to listen to "voices of the silenced other, and those marginalized by the social order" (Rice & Manderson, 1996: 320). The research employed an open-ended approach which allows participants to speak freely about their feelings and experiences using their own words rather than follow a set of pre-determined questions that are usually employed in survey research. Warr (2004), who conducted research on street sex workers, claims that qualitative methods provided her with rich and complex data that are unlikely to come to light using solely quantitative methods.

Combrinck and Reenen (2012) explained that through qualitative methods, a researcher learns about persons' lives, stories, and behaviour. In addition to learning about and understanding people's behaviour, we need to understand the meaning and interpretations that people give to their behaviour (Punch, 1998). Thus, qualitative methods can be used to discover the meanings people attach to their experiences of the social world and how they make sense of that world. The strength of the qualitative method lies in its holistic nature as it provides room to understand the interconnectedness and tensions between different dimensions.

3.3 Study population

The study population is the entire group of persons or objects that is of interest to the researcher and which meet the criteria which the researcher wishes to investigate (Brink, 2009). It includes all members of a defined group that one is studying or collecting information on for data-driven decisions. The population of the study was all disabled women in the fertility age (WIFA) group in the Tamale Metropolis.

3.4 Sample frame

Due to technical challenges involved in dealing with the entirety of disabled persons and others who associate themselves with them, the sample frame included only women who have a visual impairment, physical deformities or both. In addition, husbands and relatives (parents and siblings of those who do not have husbands) of the selected disabled persons and midwives in the study area formed the sample frame where respondents were drawn.

3.5 Sampling procedure

Tamale metropolis was purposely selected for the study because in comparing to the other districts in the region, it is the regional capital, densely populated and has the highest number of physically challenged women. In line with the theoretical underpinnings of IPA, physically challenged women and their husbands/relatives were selected using the snowball sampling method because of the scarce nature of these expected respondents. Snowball sampling techniques were appropriate for this study because these respondents were not easily accessible. At the end of the interviews, the physically challenged women and their husbands/relatives were sampled from the following communities; Kalpagyili, Kukuo, Moshe Zongo, Lamashegu, Zugund, Bipela and kateriga. Midwives were also purposely selected from health facilities in this study area. To strive for a high degree of uniformity across cases, only primiparous and multiparous disabled women in the Tamale metropolis were used in this study. To ensure these criteria were met, the researcher used the following inclusion and exclusion criterion for the selection of respondents.

3.5.1 Inclusion criteria

1. Participant must be a woman in fertility age who has given birth to at least one child.
2. Must have either visual impairment, physical deformity or both.

3. Must be a husband to a visually or physically impaired woman who is interviewed
4. Must be a relative to a visually or physically impaired woman who is interviewed
5. Must be a midwife currently working in the study communities
6. Must be willing to take part and give consent verbally

3.5.2 Exclusion criteria

1. Women in-fertility group who are not disabled.
2. Women with a visual or physical impairment who have not given birth before
3. Midwives who do not currently work in the study communities
4. Married men and relatives who do not have visually or physically impaired woman
5. Disabled women who will not give consent for the data collection due to personal reasons.

3.6 Sample size

The recruited sample for this study was not fixed but depended on the point at which thematic saturation was reached. At the point that no new themes were emerging, the sample size arrived at is shown in Table 3.1.

Table 3.1: Extimated study sample size

Category	**Sample size**
Women with disability	12
Husbands	7
Relatives	5
Midwives	6
Total	**30**

Sourec: Field survey, 2019

Interpretative Phenomenological Analysis (IPA) involves detailed analysis of verbatim accounts of a small number of participants (typically under 10), usually through semi-structured interviews (Smith, 2004). IPA researchers are interested in relatively small sample sizes so they can explore each case with the necessary time, energy, and rigour required for this type of analysis (Smith and Osborn, 2003). According to Turpin et al. (1997), the clinical psychology doctoral programs in Britain recommend that having six to eight participants is appropriate for an IPA study. A detailed analysis of a single case may be well justified if rich and meaningful data has been collected, which allows the researcher to present original problems, mechanism, or experiences. This will offer an opportunity to learn a lot about the individual, his or her response to a specific situation, and consider connections between different aspects of the person's account (Smith, 2004).

3.7 Data source

According to Pennerselvam (2007), there are two main sources of data for analysis. These are primary and secondary sources. Primary data was generated from in-depth interviews. These were elicited from physically challenged women and midwives who provide delivery services. Secondary data, on the other hand, was generated from Ghana Health Service report and a review of the literature using the internet, journals articles, magazines, books and related sources.

3.8 Data collection tools and techniques

A semi-structured interview guide (Appendix A attached) was used to explore the study objectives. According to Patton (1990), good qualitative interview questions should be open-ended, neutral, sensitive, and clear. The purpose is to give the informants the opportunity to respond in their own words and to obtain access to the informants. The interview guide was designed in line with the study objectives as an impetus for enhancing the study validity, and this was strengthened by the systematic flow of the study as a mark of reliability.

Face to face interviews was employed to collect data from the respondents. Face to face interviews was chosen as the preferred strategy because such interviews are designed to bring out the participant's detailed experiences on the research topic in their own words, with the flexibility to explore new directions within the research topic (Chadwick et al., 2008). Individual face-to-face interviews provide a relaxed atmosphere and allow observation of cues relating to participants' attitudes (Kvale, 2007; Wengraf, 2001). Open-ended questions provide opportunities to explore and retrieve meaningful and rich explanations according to the individuality of participants because those meanings and explanations differ for each person (Brownlee & Cureton, 2009). This type of questioning can also be exploited as a guide for delving down into important subjects according to the participants' point of view, rather than the researcher's (Brownlee & Cureton, 2009). Verbal informed consent was solicited from participants to commence the interviews. Data collection commenced immediately after the approval of the data collection tool by the study supervisor. Two research assistants who have in-depth knowledge in the research topic under investigation and have been in similar data collection activities before were recruited and trained to assist in the data collection. The criterion that was used for the selection of the research assistants was also based on their ability to speak and understand the local language (Dagbani) fluently.

3.9 Data analysis and presentation of results

Framework analysis approach was used in the analysis process, as this allowed themes to develop from the interactions and narratives of participants, and from the study‘s research questions (Rabiee, 2004). This seemed like the most appropriate analytical method since the purpose of the semi-structured interview was to gain a fuller understanding of the challenges that disabled women face in accessing skilled delivery services. The framework approach will involve five stages; Familiarization, Thematic framework, Indexing, Charting and Mapping and interpretation (Al-Taiar et al., 2010).

3.9.1 Familiarization

This refers to the way in which researchers become comfortable with the source material in their research study and gain a comprehensive understanding of this material in terms of both breadth and depth. Ritchie and Spencer (2003:178) suggest that this stage involves ‘immersion in the data’ via reviewing both transcripts and original data sources (e.g. audio-recordings) while keeping track of any emergent themes or relevant issues using notes. The use of research notes or memos is believed to be useful at any analytical stage in order to record insights or interpretations that may be significant or relevant to the analysis (Rothman, 2010).

3.9.2 Thematic framework

According to the framework method, ideas formulated during familiarization and after reviewing memos can be used to develop a thematic framework that is in part guided by key research aims and questions; emergent themes relevant to the study aims can be identified and sourced data can be examined, sifted and organized according to these themes. Although specific research aims and questions contribute to the thematic framework that is established, this structure is also influenced by emergent issues that may not have been considered by researchers and originate directly from the source material (e.g. discussion with participants or interview transcripts). Thus, the framework is adjusted and refined according to emergent themes when it is applied to increasing amounts of the source material.

3.9.3 Indexing

This involves applying the thematic framework to the textual source material, such as interview transcripts. This process is systematic in that all material is considered in turn and individual units of data are analyzed for their meaning and are ascribed labels or index references (thematic codes), which refer back to the thematic framework. For example, passages and sentences from an interview transcript could be annotated with index references in the margin of a page. However, there is an element of subjectivity involved in this process when making judgments about the meaning or essence of individual units of data. The referencing system helps to highlight the way in which data has been ascribed meaning and makes the process more explicit; this system can be numerical or descriptive, whereby index references are either numbers or brief textual descriptions of the data that refer back to a corresponding index of themes within the thematic framework. Multiple indexing is also possible, whereby the meaning ascribed to a unit of data may endorse more than one index reference. The process of indexing and the re-categorization element of charting could be described as coding and respectively bear resemblance to first- and second-cycle coding methods as described by (Rothman, 2010).

3.9.4 Charting

This follows the indexing of source materials and is a process used to establish an overarching understanding of the source material. Charting involves extracting data from sources and reorganizing these data into specific themes (superordinate and subordinate themes) which may derive from the thematic framework but may also include novel themes. This process allows the creation of charts whereby comparisons can be made across all participants by theme (thematic analysis) or across all themes by the participant (case analysis); this means that individual participants can be grouped according to particular characteristics and compared in terms of the themes that emerge for individuals with those characteristics. The differences and similarities within themes can also be considered because charts include carefully constructed summarized accounts of participants' indexed references for each theme, i.e. the verbatim text is not simply included in the charts. All summaries are referenced to ensure that the participant's original accounts are accessible and that the way in which summaries were created remains overt.

3.9.5 Mapping and interpretation

This involves consideration of all established themes (superordinate and subordinate themes), whereby charts and research memos are reviewed in order to meet the functions defined by the original research aims or questions of the study; for example this could involve using findings to define concepts, identify the range or nature of phenomena, create typologies via multidimensional thematic analysis, explore patterns and associations and/or provide explanations (Al-Taiar et al., 2010).

3.10 Quality control

It is the aim of every researcher to produce quality research and to obtain research results that are meaningful, that reflect reality as accurately as possible and which are replicable (Brink, 2009). Thus, in this study, the researcher employed specific measures to ensure the validity of the data collection instruments. Validity test seeks to assess the degree to which the instrument covers the scope and range of information that is sought. Existing literature was reviewed to guide the construction of the instruments. The instruments were submitted to some colleagues of the researcher and also the research supervisor for them to evaluate the questions in relation to the objectives of the study. Also, a pre-test of the instruments was conducted to further assist in fine-tuning the instrument. Finally, trained research assistants and the researcher administered the research instrument. After each day’s interviews, the researcher immediately checked to ensure that all questions applicable to the study participants were answered by the study participants and appropriately tape-recorded. The recorded data was duplicated and saved in two separate computers for safety sake. Transcription was done immediately after the data collection exercise. Data privacy was ensured as names of respondents were not written on the questionnaire or in the analysis. The process of data analysis involved member checking which was also followed by the Yardley (2000) criteria for qualitative research.

Qualitative research tends to use a range of methods for ensuring the reliability and validating of the research process (Brownlee & Cureton, 2009). The following methods were used to ensure the Validity and Reliability of Results of this study:

3.10.1 Member Checking

Member checking is primarily used in qualitative inquiry methodology and is defined as a quality control process by which a researcher seeks to improve the accuracy, credibility, and validity of what has been recorded during a research interview (Lincoln & Guba, 1985). Member checking is also known as participant verification (West et al., 2007), informant feedback, respondent validation, applicability, external validity, and fittingness (Gulliford et al., 2002). All interviewees (both the women with disability and the midwives) gave accounts of their experiences on access to skilled delivery by women with disability during the interviews; in a process of respondent validation, each interviewee was asked whether they would like to see a hardcopy version of their interview transcript for comment and 2 respondents from the midwives category requested and received their transcripts which were reviewed before results and analyses were drawn from them.

3.10.2 Yardley 2000 criteria for qualitative research

The standards by which qualitative analyses are judged are important and this study aimed to adhere to Yardley's (2000) criteria for rigorous and valid qualitative research. According to Yardley's (2000) criteria for 'good qualitative research' (p.219) in health research; there are 4 key dimensions on which qualitative studies can be assessed. These include (a) sensitivity to context; (b) commitment and rigour (c) transparency and coherence and (d) impact and importance. The ways in which this study fulfilled the criteria are outlined:

3.10.2.1 Sensitivity to context

This refers to researchers having an awareness of the various aspects of the qualitative process including the theoretical background to a research topic, relevant literature and previous empirical findings, issues relating to a study's socio-cultural setting, participant's perspectives and ethical issues. In this study, previous theory and empirical findings were thoroughly explored and a reflexive stance was taken that allowed socio-cultural contextual issues to be considered.

3.10.2.2 Commitment

The commitment was ensured in this study initially during the familiarization stage of the framework method but also throughout all stages. This involved immersion in audio recordings, interview transcripts, coding, charts and research memos.

3.10.2.3 Rigour

Rigour was demonstrated in both the breadth and depth of the sample, whereby a sample of women with various degrees of disabilities was selected and the sample size was sufficient in order to reach informational redundancy. The rigour of this study was also strengthened by undertaking various verification strategies as reported by Gulliford et al. (2002); these included: ensuring coherence between study aims and the methodology undertaken (methodological coherence); the selection of an appropriate sample; collecting and analyzing data concurrently and thinking theoretically, allowing emergent ideas to be reconfirmed in new data.

3.10.2.4 Transparency and coherence

Transparency and coherence were requirements of the framework method and attempts were made to ensure that all stages of the qualitative process were clearly described. Interpretive charts and extracts from interview transcripts were made visible to allow readers to clearly identify suggested interpretations, associations, and patterns within the data.

3.10.2.5 Impact and importance

Impact and importance refer to the extent to which findings enrich understanding and can be utilized by the community for whom it was intended or deemed useful based on study objectives. The relevance and implications of the findings for this study are outlined in the intended benefits section of the study report.

3.11 Intended benefits

Benefits refer to the extent to which findings enrich understanding and can be utilized by the community for whom it was intended or deemed useful based on study objectives. This study was conducted to provide local and contextual knowledge and expressions by disabled women on access to skilled delivery. It is one of the few studies that have explored the challenges associated with patronage of skilled delivery services among disabled women in Ghana and the Northern Region for that matter. Although similar investigations associated with disability have been conducted in previous studies, this exploration was novel in that, the generated themes were elaborated and considered in terms of the ways in which they interact with one another. The outcome could be incorporated locally into the design, administration and implementation of childbirth programs in communities in Ghana and other rural settings to favour this category of WIFA. The findings would also inform policymakers and programme managers of some possible missed opportunities worthy of consideration in the implementation of programmes related to disabled pregnant women perception of skilled delivery services. Governmental organizations such as Ministry of Health (MoH), Ghana Health Service (GHS) and the Tamale Health Directorate, and other non-governmental organisations would find information from this research useful in the design and planning of their health programs especially concerning disability and skilled delivery. It would yield information that would add to the existing knowledge in academia and research in the field of disability and childbirth practices among disabled women and related issues in the Tamale Metropolis and Ghana as a whole. Other researchers would also use the findings to advance their arguments on related matters in maternal health care.

3.12 Ethical procedure

A research project is a process which has ethical implications. Therefore, the researcher conducted this research taking into consideration the ethical issues. The following three fundamental ethical principles guided the researcher; respect for persons, respect for beneficence and respect for justice. These principles are based on the human rights that must be protected during any research project, including the right to self-determination, privacy, anonymity, confidentiality, fair treatment and protection from discomfort and harm. An introductory letter was obtained from the University for Development Studies through my research supervisor that was used to obtain permission from the necessary authorities to commence the data collection process.

In this study, the research participants were informed that they had the right to withdraw from the study at any time, the right to refuse to provide information and the right to ask for clarification regarding the study. Verbal informed consent was also sought from the study respondents before the administration of the data tool. The researcher also explained to each participant that she could request a transcript of the interview and that the recording would be destroyed after transcription and analyses and acceptance of the thesis work. In order to ensure confidentiality, the researcher made sure that no information provided by a participant during the course of the study was either divulged or made available to any person other than the supervisor of the study. In addition, the completed dissertation did not mention any of the participant's names.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter consists of the findings and is presented in both tables and narratives from respondents under the various themes. Responses from the different categories of respondents are merged together in the presentation. Where quotations are used; WWD represents a woman with a disability, H represents husband, R represents relative and MW represents midwife.

4.2 Background characteristics of respondents

This section presents information on the background characteristics of respondents. The characteristics of physically challenged women are summarized in Table 4.1.

Table 4.1: Socio-Demographic Characteristics of physically challenged women

Variable		Frequency	Percentage (%)
Age	31-35	1	8.3
	36-40	3	25.0
	41-45	8	66.7
	Total	**12**	**100.0**
Marital status	Single	5	41.7
	Married	7	58.3
	Total	**12**	**100.0**
Religious affiliation	Christian	2	16.7
	Muslims	10	83.3
	Total	**12**	**100.0**

Occupation	Unemployed	2	16.7
	Petty trading	7	58.3
	Salaried worker	3	25.0
	Total	**12**	**100.0**
Educational level	No formal educ.	3	25.0
	JHS/Middle School	4	33.3
	SHS	2	16.7
	Tertiary	3	25.0
	Total	**12**	**100.0**
Ethnicity	Dagomba	10	83.4
	Ewe	1	8.3
	Akan	1	8.3
	Total	**12**	**100.0**
Parity	One child	7	58.4
	Two children	4	33.3
	Three children	1	8.3
	Total	**12**	**100.0**
Type of disability	Visual impairment	3	25.0
	Physical impairment	9	75.0
	Total	**12**	**100.0**
Use of Aid	Yes	2	16.7.0
	No	10	83.3.0
	Total	**12**	**100.0**

Source: Field data 2019

From Table 4.1, about 67% of the respondents were aged between 41 – 45 years while 8.3% were aged between 31-35 years. Nearly 42% of the respondents were single women whiles about 58% were married women. A little over 83% of the respondents are Muslims with only 2 out of 12 being Christians. In the occupation classification, over 58% are petty traders as against 25% salary workers. Only 2 participants (17.7%) indicated they were unemployed. Twenty-five per cent of the respondents did not have any formal education whiles the same percentage indicated tertiary as their level of education. The rest had their highest education up to the JHS (33.3%) and SHS (16.7%) levels. The results also showed that more than 83% are Dagombas with 1% each as Ewe and Akan. About 58% of the respondents had one child at the time of the study whiles 33.3% had two children but only one participant had 3 children. For the type of disability, 75% are physically impaired whiles 25% are visually impaired. Nearly 84% are able to carry on with their daily lives with the use of any aid whiles the remaining 2 (16.7%) uses aid to assist in their daily lives.

With regards to the midwives, 50% of them have had between 5-9 years working experience in the Ghana Health Service (GHS), about 33% had over 10 years of working experience and 16.7% had less than 5 years of working experience in the GHS. For experience in working in the study metropolis, 50% of the midwives have worked in the study metropolis for more than 5 years while the same number also had less than 5 years working experience in the study metropolis. With regards to the position held by the midwives in the maternity unit, 83.3% indicated they were the heads of the units whiles only 1 (16.7%) said she was an assistant head of the unit. All the husbands and relatives interviewed are currently living with the disabled women through whom they were selected for the study.

4.3 Cause of disability

The interviews sought to find out the causes for the disabilities and this yielded three sub-themes; accident, disease and don't know the cause of the disability.

4.3.1 Accident

Eight out of the 12 women disabilities indicated that their disabilities were as a result of road traffic accidents that affected their lower limbs. As stated by some of the respondents:

*"We were involved in an accident. I was even lucky because some people died but for me, my leg got broken and I also had some brushes over my body" (*WWD from Zugund).

"It was a motorbike. I was sitting at the back and the rider crushed with another motorbike. I and the other motorbike rider both had fractures but for my own, they did not cut my leg" (WWD from Kalpagyili).

"I was travelling and got involved in an accident but thank god I didn't die. I was travelling to my home town and got involved in a car accident and broke both of my legs" (WWD from Bipela).

"it was a motorbike accident. I was riding myself and had the accident. I entered into a pothole and lost control and that made me had the accident. (WWD from Lamashegu).

Their husbands also made the following expressions;

"It was an accident. My wife travelled to the south and on her way coming, she had an accident. According to what I heard, some people even die" (H from Lamashegu).

"My wife got into this condition because of a motorbike. That time she was actually not perfect in riding. She left one morning on the motorbike to visit a friend and on her way back she had the accident" (H from Kukuo).

Another also said, *"Hmmm, I was actually surprised, my wife has been riding for long but that day was not lucky for her, she crushed with another motorbike and it ended her this way"* (H from Moshe Zongo).

Their relatives also commented on the causes in relation to accidents:

"My sister was involved in a car accident and this is what happens to her. We did not even think she could survive it because fractures were very serious but thank God she is still alive for us" (R from Kalpagyili).

"..., it was an accident. The accident was very serious so we thank god for my sister being alive and having this condition. She went home and on her return, the accident happened" (R from Kateriga).

"My daughter got involved in a motor accident. She had multiple fractures, both legs and the ribs. We tried all that we could but still, she couldn't regain her physical self" (R from Bipela).

The midwives also commented as follows:

"Apart from some few physically challenged women *in the reproductive age as a result of diseases, the majority of them is as a result of a motorbike or car accidents. I am not saying riders her a careless, but their riding is various dangerous to many lives"* (MW from Central Hsopital).

"they are caused by road accidents. The disabilities in this area are mostly due to motor accidents. Go to the accident unit and see, almost all are due to motorbike" (MW from SDA Hopital).

4.3.2 Disease

The only one person who mentioned disease as the cause of her disability said, *"my leg was chopped off because of diabetes"* (WWD from Moshe Zongo). Her husband also said *"my wife's condition is as a result of diabetes. The doctors said it was diabetes but the only thing they can do to help her was to cut the leg"* (H from Moshe Zongo).

Three of the midwives also mentioned disease as a cause of disability.

"Some diseases like trachoma and diabetes can cause some women to have disabilities. Trachoma can lead to blindness and there can be leg amputation due to diabetes" (MW from Teaching Hopital)

"Apart from accidents, the disease can also make you disabled. There are some diseases when you get them it will destroy somebody parts making that part not to function well again. For instance, if you get polio at infancy, it can cause permanent paralysis" (MW from Teaching Hospital).

4.3.3 Unknown causes of the disability

Three of the women could not identify what was the cause of their disability. This was a peculiar issue for visually impaired women. They did not know exactly what the cause was but one of them feel that it was the work of the devil. These were their sentiment expressed:

"Hmmm, this thing just happens and no one can tell what is causing it, I have been seeing well and suddenly my eyes started paining me seriously and within a week, I could not see well again. With this how can I know the cause?" (WWD from Kateriga). One also said:

"The way the whole thing happened it is not easy to say the cause but I think the devil has a hand inside, because me I was not sick but now, I cannot see well" (WWD from Kalpagyili).

4.4 Disability experience

When the researcher asked respondents to talk about disability experience, two key issues came out; the disability affects their own life and the disability affects the lives of their close ones.

4.4.1 Effects of Disability on daily life

All the respondents lamented their inability to excel in life as a result of their disabilities. They all said, it has affected their lives in such a way that they cannot do certain things on their own unless with the help of another. It was also revealed that, because of their disabilities, at times they feel shame to take part in some social activities that could have had a positive impact on their lives. As stated by some of the respondents:

"I would have a wish to also walk normally like I use to do so that I can freely do my business, but because of my leg, I cannot do my own business the way I wanted it" (WWD from Bepila).

"I use to do my own housework and also go the market to sell my thing, but now, how can I work in this condition? I can't do anything productive unless my family helps me" (WWD from Kateriga)

Another participant has this to say; *"Some people don't fear God. You see with this our problem some people will see you and make a mockery of you as if you are the cause of your own problem. They can even hide and call you a witch some I don't always want to go near where people are gathered"* (WWD from Kalpagyili).

Their husband and relatives also shared their views as follows:

"When my wife's leg was cut, it has not been easy. She has to stop her trading business and currently doing nothing and this is really affecting the family" (H from Kukuo).

"Her condition is affecting her and the family, sometimes I can see the pain in her eyes so I know she is going through a lot. Now she lives like a child who cannot do anything on herself" (H from Zugund).

"My sister was very active but now I can see that she actually wanted to do like she used to, but it is not just working out. My sister is not having it easy only that we are comforting her" (R from Moshe Zongu).

"…, but how can somebody be in this situation and it will not affect her? My daughter is going through a lot of discomforts and unsatisfying life only that am trying my best to let her understand that all is not lost" (R fromBipela)

4.4.2 Effects of Disability on Family members and relatives

It came out during the interviews with the physically challenged women that, their impairment goes beyond them to affect their families and even friends who sympathize with them. These are some quotations from their responses:

”*Concerned family members and friends contribute in various ways to my daily life. Sometimes they provide for them or spend time to do something for me to make me comfortable”* (WWD from Kalpagyili).

“Some family members will have to combine their daily work with what the women with a disability could have been doing. My mother now has to combine her trading business with that of my responsibilities. I use to help her a lot in the trading business but now I can just do a little to help. My mother is overworking these days because of my condition” (WWD from Kukuo).

“My husband has taken up a lot of my daily routine household work. Sometimes I will even want to do it myself but he will not agree. This is affecting his own work but he is coping with it” (WWD from Moshe Zongo).

“…, also, I still do some work but my sister who is staying with me does most of the things in the house. I sometimes see that she is tied but there is little I can do to support” (WWD from Lamashegu).

These were the expressions from their close ones:

“…, I think it is too much a headache, just that sometimes I need to squeeze time from work to support my wife in the house to take care of the children and other things, but just as I said, it is normal” (H from Moshe Zongo).

"She is my life partner and even though she is still doing well in her condition, she thinks she is not doing her best and that makes me feel unhappy all the time" (H from Kalpagyili).

"With my wife's condition, I do not have a problem, she is still doing her best, just that I now have to help her more in the house and also financially" (H from Kukuo)

"My daughter was doing everything for me in my store but now I have to employ somebody and pay the person. ..., but she is still doing well only that I miss her activeness in my business" (R from Lamashegu).

"My sister was the one taking care of us and now because of her situation, we are also facing a lot of problems. She was paying our last born school fees but now she finds it difficult to do it alone" (R from Bipela).

4.5 Knowledge of women with disability about skilled delivery services

To ascertain the challenges that physically challenged women face regarding access to skilled delivery, the researcher first sought to unearth their knowledge of skilled delivery services. Their responses were grouped into the following sub-themes; deliveries assisted by health staff and deliveries done in a health facility.

4.5.1 Deliveries assisted by health staff

All respondents made mention that skilled deliveries are those that a health worker assists in delivering. Their responses are summarized in Table 4.2.

Table 4.2: Category of health staff who assist in delivery from the perspectives of physically challenged women (n=12)

Response	Frequency	Percentage (%)
Doctors	8	66.7
Midwives	11	91.7
Nurses	6	50.0
Health workers	10	83.3

Multiple responses ***Source: Field Survey 2019***

From Table 4.2, the majority (91.7%) mentioned midwives as those who assist in deliveries followed by 83.3% who just said health workers and explained that every health worker present during labour can assist in delivery. As stated by some of the respondents:

*"If you go to the health facility and a health staff assists you to deliver, it is skilled delivery. ... once the person is a health staff and work in the facility, he/she can help you to deliver even if he/she is not a midwife, and when this happens, it is called skilled delivery"(*WWD from Moshe Zongo).

Respondent WWD from Kateriga also expressed her knowledge of skilled delivery as *"this day it is the skilled deliveries that we all know because there is a lot of education that we should not deliver at home, so if you go to the hospital to deliver and a health staff takes care of your delivery, then that is skilled delivery"*

Another participant also pointed out that *"skilled deliveries are deliveries conducted by health staff, especially doctors and midwives in the health facilities" (WWD from Zugund).*

4.5.2 Deliveries at the health facility

Probing further, all respondents indicated that deliveries conducted in a health facility are skilled deliveries. To them, once the person is able to reach a health facility and the baby comes out, it is a skilled delivery. As stated by some of the respondents:

*"Skilled delivery, ... now everybody who gets pregnant doesn't want to deliver in the house because she can die or the baby can easily die. Because in the house, your mother or the TBA will not have the logistics to be able to prevent you from dying if you are breeding too much. Now everybody knows that if you are in labour, you should try and go to the health facility to deliver, and this is skilled delivery" (*WWD from Lamashegu).

"If you deliver in a health facility that is a skilled delivery. The health staff are there to take care of you. Their environment is also good than the house so you will feel safe" (WWD from Kalpagyili).

"Skilled delivery is when a skilled health worker helps you to deliver in a hospital or clinic. This the doctor, the midwives or even sometimes other health staff will help you to deliver and they will give drugs stop the bleeding and the pain" (WWD from Kukuo).

4.5.3 Source of information on skilled delivery services

As part of ascertaining respondents' knowledge, interviewees were also asked to indicate their major source(s) of information about skilled deliveries. The information is presented in Table 4.3.

Table 4.3: Source of information on skilled delivery services (n=12)

Response	Frequency	Percentage (%)
Health staff	12	100.0
FM stations	9	75.0
Family members	7	58.3
Friends	7	58.3

Multiple responses ***Source: Field Survey 2019***

All participants mentioned health workers as their major source of information. Additionally, 75% cited FM stations and 58.3% each mentioned family members and friends as their additional sources. A respondent answered the question in the following expression:

"This one we don't hear it from one source, these days the health workers have put out the education such that apart from the health workers, you can hear this from your own house members, friends and even on the FM stations" (WWD from Lamashegu).

4.5.4 Knowledge of midwives on skilled delivery services

The researcher also explored the knowledge of midwives in the study metropolis to support and better understand the challenges faced by physically challenged women in accessing skilled delivery services in the area. All midwives (6/6) indicated that they have heard and learned about skilled delivery during their formal midwifery training. They explained that skilled deliveries are deliveries conducted by qualified health personnel who are trained and certified to conduct deliveries.

4.6 Patronage of skilled delivery services

This section presents findings on the extent to which physically challenged women utilizes skilled delivery services

4.6.1 Patronage of skilled delivery services by women with disability

With regards to patronage, the researcher sought to ascertain whether or not interviewees delivered their last child in a health facility and indeed was attended to by a skilled delivery services provider. The responses are summarized in Table 4.2.

Table 4.4: Patronage of Skilled Delivery services by physically challenged women (n=12)

Variable		Frequency	Percentage (%)
Place of delivery of last-child	Health facility	9	75.0
	Home	3	25.0
Who delivered you	Midwife	7	58.3
	Doctor	2	16.7
	TBA	3	25.0

Source: Field Survey 2019

Table 4.4 indicates that 75% of the interviewees delivered their last children in a health facility and were attended to by a skilled attendant as against 25% who delivered at home and were attended to by a TBA. Respondents were further asked to provide reasons for their choice of delivery sites and it was revealed that the majority (88.9%) of those who delivered at the health facility did so because that place was safe for them. Another reason was that it was a decision they took during pregnancy to deliver at the health facility that was why they honoured it. For those who delivered at home, the common reason was that the baby came out suddenly. Few minutes after they started feeling the pain of labour, the baby came out. This was from one participant:

"I did not decide to deliver at home, just that I could not control the coming of the baby, when I felt that I was in labour, we started preparing to go to the hospital and suddenly the baby started coming out, so they rushed and called the TBA to come and assist me to deliver" (WWD from Moshe Zongo).

4.6.2 Provision of skilled delivery services to physically challenged women

With regards to the provision of skilled delivery services to physically challenged women by health workers, the researcher wanted to know how often physically challenged women deliver in the health facilities. The results were that two midwives have ever delivered two (2) women with physical impairment each and three midwives have ever delivered one (1) woman each with physical impairment. All these deliveries were normal deliveries. The other midwife said she has never delivered a disabled woman before. The interviews were supported by evidence from records of the hospital. The findings from the hospital records are summarized in Table 4.5.

Table 4.5: Deliveries by physically challenged women, February 2018 to January 2019

Variable		Frequency	Percentage (%)
Type of delivery	Normal deliveries	8	88.9
	Caesarean section (CS)	1	11.1
	Total	**9**	**100.0**
Age of mother at delivery	26-30	1	11.1
	31-35	1	11.1
	36-40	3	33.3
	41-45	4	44.5
	Total	**9**	**100.0**
Marital status of mother at delivery	Single	3	33.3
	Married	6	66.7
	Total	**9**	**100.0**
Parity	One child	2	22.2
	Two children	5	55.6
	Three children	1	11.1
	Four children	1	11.1
	Total	**9**	**100.0**

Source: Field data 2019

Table 4.5 shows that nine physically challenged women (8 with physical impairment and one with visual impairment) delivered within the record review period in the study facilities. Whiles eight deliveries were conducted normally, the remaining one was delivered through CS. A majority (77.8%) of the mothers were between the ages of 36- 45 years. Six out of the nine were married physically challenged women and the majority (55.6%) had two children.

The researcher further asked the interviewees what support do physically challenged women get from partners or families during labour and delivery. All the midwives indicated that relatives were very supportive in bringing the women in labour to the facilities and throughout the delivery process. One midwife expressed her view in this form:

"Ooh, their people did very well, they brought her immediately she started experiencing the labour pains and in fact when they got here, they were very supportive. Anything you ask them to do, they quickly do it" (MW from Teaching Hospital).

4.7 physically challenged women' perception of skilled delivery services

After ascertaining their knowledge on skilled delivery and where they delivered their last child, the researcher sought to find out their perception on skilled delivery services provided to physically challenged women, whether or not it was good and the reasons for their perception. The study found three perspectives about services rendered; the services are good, the services are bad and there are no services for physically challenged women.

4.7.1 The services are good

Out of the 12 respondents, only one (8.3%) indicated that the skilled delivery service for physically challenged women was good. One of the women who suffered from leg amputation said she was treated with respect by the doctor who delivered her. This was what she said:

*"For me it is good. That delivery was my first delivery and I delivered through an operation. The midwives did very well. They tried to help me deliver by myself but I couldn't, so the doctor has to operate me. And the way they were all happy about me getting my baby alive, I was so excited. ...the place is not bad but I think they should have had a separate room for we those who have challenges. Also, I found it difficult to use the steps so I think they should have made a special climbing place for us" (*WWD from Zugund). The husband confirmed this by saying; *"..., I was with my wife at the hospital where she delivered, and the midwife, in fact, all the nurses there treated her well. Based on this I can say their services are good. ....for the infrastructure, I think it should have been best and more comfortable if the services provision room for physically challenged women was separated from their counterpart abled women"* (H from Zugund).

This was what one midwife also said; "*physically challenged women for that matter have special needs, and when they come to deliver they are treated in a special way so they will definitely think our services are good to them"* (MW from Teaching Hospital).

4.7.2 The services are bad

The perception of the majority ((83.4%) of the interviewees was that skilled delivery service for physically challenged women was bad. The following were mentioned as the reasons why they perceived it as bad; there are no provisions for physically challenged women, physically challenged women are sometimes treated by health workers as if they were responsible for their own disabilities, physically challenged women pay for services just like those without disabilities and finally, physically challenged women will have to be with women without disability in the same room to receive services. As stated by some of the respondents:

"Aaaaa, what are they doing to us, their services are very poor, they don't know how to treat people with this our problem, they just look at you like you are not like them, ..., for me if anybody asks me this question I will tell the person the truth that their services are bad, I am not afraid. ..., they will just pack you together with those who do not have these challenges at the same place, how can we be comfortable? They need to separate us from the rest when we go to the hospital" (WWD from Kalpagyili)

"I have not seen anything special for those of us with this problem, the truth is that provision of delivery services, in general, is bad so as for physically challenged women. So if you ask me I will say that the services are not good at all, how can somebody like me come to your facility to deliver and you treat me like I don't know my left from my right?, if you are the one will you say it I good?" (WWD from Kukuo).

These were some expressions from husbands and relatives:

"..., they should have had special units in the hospital and special treatment for women with this type of condition, but it is not there, so they treat them like those without any problem which is bad" (H from Lamashegu).

", you see, physically challenged women already have their own problem but when they go to the health facility they are not seen like that. Health staff treat them as if they are the cause of their own disability" (R from kalpagyili)

Midwives also added the voice:

" Because people generally perceive health services delivery as bad, so do physically challenged women also see skilled delivery services. The reality is that the provision of the current services is not able to address the needs of physically challenged women who access our facilities" (MW from Teaching Hospital).

"For me, I think because of infrastructure challenges, they will perceive skilled delivery services as bad but this beyond our control as midwives. The infrastructure is a management issue, we always complain but no changes" (MW from SDA Hospital).

4.7.3 There are no services for physically challenged women

One person (8.3%) was indifferent about services to women with disability. For her, there are no special skilled delivery services for physically challenged women based on which she can judge whether it was good or bad. She indicated that:

"physically challenged women go through the same system as those without disabilities. I do not see any special services that are purposely there for physically challenged women. If the special service was there, I can now say whether it is good or bad, but it is not there" (WWD from Moshe Zongo).

One relative also said; *"For me, I do not know of any special services for physically challenged women so I can't tell whether it is good or bad"* (R from Kalpagyii)

4.8 Challenges in accessing skilled delivery services

This section sought to ascertain the views of respondents on the challenges faced by physically challenged women in accessing skilled delivery services. To explore this, the interviewees were asked to provide information on challenges they had faced previously in accessing skilled delivery services or any challenges they know physically challenged women go through in accessing skilled delivery services. At the point of thematic saturation, the following sub-themes emerged as the challenges faced by physically challenged women in accessing skilled delivery services; staff attitude, cost of services, inadequate family support, the attitude of other health seekers and lastly, infrastructure not disability friendly.

4.8.1. Staff attitude

Findings from the interviews show that service providers do not show any respect for persons with disabilities. To some extent, some can tell them who asked them to become pregnant. One aspect of services provided to physically challenged women is for the service providers to assist them at the facility but unfortunately for some of them, even to assist a disabled woman to climb or get down from a bed is none of their business. It came out that sometimes physically challenged women were treated as if they were responsible for their situations. These were some quotations of their expressions;

"The midwives don't fear God at all; see if you go there, they treat you like a child. Any small thing they will be shouting at you. When they do this, you are disgraced, you see" (WWD from Bipela)

"…even if you need their assistance, they will ignore you and call on your relatives to offer that assistance. Sometimes it looks as if you should even cry" (WWD from Kalpagyili)

Expressions from their husbands and relatives:

"Some of the nurses do not care about women who have these disabilities, they shout at them. We the relatives always assist them because we understand them better" (R from Kateriga).

"*There was a day a took my sister who cannot walk to one of the health facilities in town, I almost cry because of what the nurses did to her, my sister was ashamed"* (R from Bipela)

"One of the challenges is how the health staff talk to these physically challenged women. They will shout at them as they do to any other person, but I think they should have been mild towards these women" (H from kukuo)

4.8.2. Cost of services

The cost of delivering in the health facility is high as indicated by the majority (91.7%) of the interviewees. With health insurance in existence, but women still pay when they go to deliver at the health facility. What is making the cost even high is that when you are getting to delivery, the midwives will give you a list of items to be bought and brought on the day of delivery and if you are not able to get these items, you will pay for it. The cost was extended to cover transportation cost as it was captured in the interviews of some interviewees that one will have to hire a vehicle to be transported to the facility because one cannot walk when in labour. These were their expressions:

"When you go to the health facility to deliver, they demand so much money from you. They will say go and buy this or this is not there, bring money and so many things. They will collect small-small money, but when you finish and check all, it is not small" (WWD from Kalpagyili).

"When you are about to deliver, they will give a list of items to buy in preparation for the delivery. They will ask you to buy many things which are costly" (WWD from Lamashegu).

"They collect money too much. Any small thing they will tell you it is not there so go and buy. Even if you have insurance, you will still pay some money. They will tell you that one is not insurance" (WWD from Moshe Zongo).

"…, but when I took my wife to the hospital to deliver I still have to pay money, not a small amount. So you see, if there is somebody who cannot pay, means the person will not take the wife there. Even before the day of delivery, look at the items you will buy, it is no small thing" (H from Kateriga).

"…, madam, delivery at the hospital is costly, look, you will be asked to buy a long list of items, when your wife is in labour and you do not have means, you will hire a taxi and the painful thing is that even if you have insurance forget because you will still pay money after the delivery" (H from Kukuo).

"The way the midwives will charge you is not good. You see, you will struggle and do insurance, but, they will still charge you when you take your daughter there to deliver" (R from Moshe Zongo)

4.8.3. Inadequate family support

As part of their challenges, it also came out that they do not get the needed support from their relatives in terms of financial or even decision making. For some (5/12) of them in their own expressions, their disabilities have affected their economic activities and because of that, they are not able to raise enough funds for skilled delivery services. Also, because they are financially handicap, people who will support them financially in most cases lead the decision making whether or not to start going to the health facility. It was also revealed that some family members are willing but are also financially constrained but some are actually not concerned about them at all. As stated by some of the respondents:

"Some of our family members will like to support but they are also like us, they don't have money but some of them, hmmm, I can't talk much" (WWD from Kateriga).

"Because you do not have the money yourself if they don't say they are taking you to hospital, you cannot take any decision" (WWD from Kukuo).

"For me, if I am to deliver and you take me to the hospital, I will go. The last time I delivered in the house because nobody offered to take me to the hospital so it was not my fault" (WWD from Kalpagyili).

"It can happen that I will not be in the house and my wife is in labour. Before they will me or look for me to get to the house, maybe, she has already delivered, you see" (H from Moshe Zongo)

"The woman can be in labour and the husband is not there so what can I do? I am also an old woman so I can assist her to deliver" (R from Moshe Zongo).

4.8.4. The attitude of other health seekers

Aside from the attitude of health staff, it was also revealed that, the attitude of other persons who are also in the health facility to seek health care sometimes make it uncomfortable for physically challenged women to enjoy their skilled delivery services. Some people are generally good but for others; the look alone will make you uncomfortable. One woman said this;

"When they are there first and you enter, you will see all of them looking at you as if you have done something wrong. When they do that it makes you uncomfortable" (WWD from Lamashegu)

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This chapter is a presentation of the discussion of the results. The discussion is presented according to the results of the study and supported by existing literature. The discussion is organized to reflect the objectives of the study and captures inferences for which reason the research was carried out and giving alternate explanations for the outcomes. The study was conducted to explore the challenges associated with patronage of skill delivery services by physically challenged women in the Tamale Metropolis. The study took into account the disabled women, their husbands/relatives and midwives. The reason for a discussion to be a chapter on its own in this research is that it presents a "frame of the finding of the current research investigation in light of the previously published research" (Amonette, English & Kraemer, 2016, p.79). This section gives the researcher room to provide a deeper and broader interpretation of the results and likely implications that may have been the practice depicting what has been found to be the case. It, therefore, means that this chapter explains the meaning of the results, the reason for why things are the way they turned out, and the way the results can be put into good use or practice (Polit & Beck, 2006).

5.2 Knowledge and patronage of skilled delivery services by physically challenged women

The researcher explored the knowledge of physically challenged women regarding what is referred to as skilled delivery and in addition assessed their patronage of these services. The findings revealed that the majority (91.7%) of the respondents asserted that deliveries conducted by midwives are referred to as skilled deliveries. This was closely followed by 83.3% who also mention deliveries conducted by health workers in general as skilled delivery and explained that every health worker present during labour can assist in delivery. As to how they got the information regarding skilled delivery services, all respondents said health workers are the sources of their information, with 75% citing FM stations as the second source of their information regarding skilled delivery services. These responses depict a fairly high level of knowledge exhibited by respondents with regards to what constitutes skilled delivery service. Adequate knowledge of health service has been found in several studies to influence health services utilization (West et al., 2007). This study found that all respondents indicated that deliveries conducted in a health facility setting and attended to by a health worker are described as skilled delivery services. They also explained that skilled delivery was the best option because health workers are able to respond to emergencies in a better way than home delivery. Thus it might be expected that with 100% of respondents exhibiting this fairly high knowledge, a similar trend will be seen in the utilization of skilled delivery services by physically challenged women. However, having knowledge alone may not always result in best practices (McColl, 2005). This current study, however, found that only 75% of the women with disability interviewed delivered their children at a health facility and were attended to by a skilled attendant despite the demonstration of high knowledge. This is similar to results found by previous studies in which contradiction was observed between knowledge and patronage of delivery services (O'Hearn, 2006). This could be attributed to challenges such as physical barriers, financial barriers and physician barriers (Iezzoni et al., 2010; O'Day et al., 2002; West et al., 2007).

5.3. physically challenged women' perception of skilled delivery services

The researcher further assessed the perception of physically challenged women regarding skilled delivery services. Only one (1) respondent representing 8.3% said the services she received at the health facility was good as against the majority (83.4%) of the respondents who said that skilled delivery services were bad and attributed it to lack of provision for physically challenged women, physically challenged women sometimes not treated nicely by health workers, physically challenged women are made to pay the services and using one room for both disabled and abled women. This finding is a confirmation of the study finding by Bjom (1990), which says less stimulation, less attention, less medical care, less education, less attention is accorded to disabled women and thus minimizing their patronage of skilled delivery services. This perception could also be an explanation of why only 75% of physically challenged women patronized skilled delivery services in the study area. Studies conducted by Buj (2010) relating to attitudes and perceptions of persons with disabilities towards skilled delivery also revealed that majority of physically challenged women are of the opinion that nurses and midwives are not versed with sufficient experience, nor requisite skills and knowledge of how to handle physically challenged women. Their findings further stressed that, indeed, physically challenged women do not only complain about a lack of technical knowledge of these nurses and midwives but also about their unhelpful attitude. Other researchers have shown that many service providers have little experience of disabled people's needs (ESCAP, 2003). physically challenged women perception of health facilities quality are ultimately hinged on the interaction they have with nurses, thus, nurses must, therefore, ensure that every service encounter with physically challenged women will positively influence their evaluation of the facility experience. Research has also affirmed that training is a key avenue through which a change in the attitudes of persons without disabilities towards those with disabilities can be effected (Daruwalla & Darcy, 2005), hence, refresher training of nurses and midwives could help to improve on service delivery to disabled women.

5.4 Challenges in assessing skilled delivery services

The main objective was to assess challenges that women with disability face in accessing skilled delivery services. Interviewees were quizzed as to the challenges they encounter in accessing skilled delivery services at health facilities. Respondents cited the following as challenges that mitigate their effort against patronizing skilled delivery services; the attitude of health staff toward them during facility visits. These findings go to confirm the findings of O'Hearn, (2006), some barriers that put persons with disabilities at a significant disadvantage at accessing skilled delivery services are the attitude of staff and financial barriers. Some of these barriers overlap with one another and have been referred to interchangeably by different authors. Various studies also cite challenges facing access to health care as programmatic barriers (Yee & Breslin, 2010), structural and procedural barriers (Hwang et al., 2009), physician and financial barriers (O'Day et al., 2002), environmental and process barriers (Kroll et al., 2006) and physical barriers (Iezzoni et al., 2010). These barriers can occur in isolation or, more commonly, in an interaction with one another. Though there is no consistency amongst disability researchers about what might constitute the greatest challenge facing persons with disabilities, some researchers postulate that negative staff attitudes are the greatest limiting barriers (Lagu et al., 2014) Other researchers advance the preposition that societal attitudes towards persons with disabilities are the most potent and negative stressor in their lives (Hannon, 2007), while others identify the aspect of health care infrastructure as the greatest (Vignuda, 2001). Problems with access to skilled delivery can lead to exclusion of physically challenged women from health services or lead physically challenged women to delay in seeking health care. Lack of knowledge on health-related issues often makes persons with disabilities less assertive in seeking specific services because they usually are lost as to where to go to access that specialized service while the lack of funds may make it difficult for physically challenged women to seek for more expensive specialized health care from a specialist even if they are able to locate the specialized services. Difficulties with transportation often emanate from lack of funds to board public means and the difficulties of physically challenged women driving (Tamasker et al., 2000). In a similar development, a study conducted by Abdulrahman (2015) revealed that disabled women faced challenges such as inadequate healthcare facilities and inadequate skilled personnel to assist them during delivery. It is in line of this that Deines-Jones (1999) cited in Carter (2004) that, staff training is paramount in the delivery of their duties which will culminate into improving the sensitivity and awareness to issues related to disabled women. Besides, the cost of services provided at these health facilities is exorbitant posing as a challenge for these disabled women. Confirming a study by Irvall and Nielsel, (2005), which says that on the part of financial support or cost or payments made by disabled women, should be cushioned by government or civil society organizations or non-governmental organizations. The midwives were also asked about the challenges they face in providing skilled delivery services to physically challenged women to complement what was cited by physically challenged women. These were cited as challenges health workers face in their line of duties in providing skilled delivery services to physically challenged women; inadequate staff, frequent shortages of basic delivery logistics, lack of facility for women with disability, too much pressure from the relatives, lack of special training of health workers to handle disabled women and lack of motivation.

Lack of special training for health staff with regards to how to handle physically challenged women could lead to the negative staff attitude as cited by the physically challenged women, even to some extent, some midwives would say I am not the one responsible for your pregnancy or who asked you to become pregnant. Such humiliating statements from health workers dampen the spirits of physically challenged women as confirmed by Disability Discrimination Act (1995), which talks about attitudinal discrimination, discourteous and impatient against disabled women by staff members of health facilities. Again, because the health facilities are not disability friendly thus the infrastructure and the facilities within the health facilities coupled with the calibre of health workers give them a huge challenge in accessing health facilities as asserted by Bodaghi, Zainab & Noorhidawati (2014). Lagu et al. (2014) stated that barriers to access are the result of a variety of physical, policy, procedural and attitudinal factors and we need to begin to characterise these barriers and identify domains (or axes) that will help improve and achieve access to health care. Irvall and Nielson (2005), posited that health care staff must be trained and given adequate skills and be well informed about the categories of disabilities and how to manage or handle them during skilled delivery.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This is the final chapter of the study that comprises a brief summary of the major study findings, conclusion based on the objectives of the study and recommendations based on the results and the discussion of the study.

6.2 Summary of findings

The following are the key findings of the study based on the responses gathered from the interviews conducted.

1. About 67% of the disabled women interviewed were above 41 years of age and close to 42% were unmarried women.
2. The results show accidents and diseases as the causes of their disabilities.
3. It was highlighted by the disabled women interviewed that, their disability affects their own life and the lives of their close relatives.

4. Regarding knowledge of skilled delivery, about 92% mentioned deliveries conducted by midwives in a health facility as skilled deliveries.
5. Health staff was mentioned as the major source of information on skilled delivery services by all respondents followed by FM stations (75%) as a second source.
6. Seventy-five per cent of women with disability interviewed said they delivered their last child in a health facility assisted by health staff (midwives-58.3% and doctors-16.7%).
7. The study found three perspectives with regards to their perception to skilled delivery services; the services are good (8.3%), the services are bad (83.4) and there are no services for physically challenged women (8.3%).
8. The following were mentioned by women with a disability as challenges faced by physically challenged women in accessing skilled delivery services: staff attitude, cost of services, inadequate family support, the attitude of other health seekers and lastly, infrastructure not disability friendly.
9. The following were also mentioned by midwives as challenges they faced in providing skilled delivery services to physically challenged women: inadequate staff, frequent shortages of basic delivery logistics, lack of separate facilities for physically challenged women, too much pressure from the relatives, lack of special training of health workers to handle disabled women and lack of motivation

6.3 Conclusion

The study was an explorative qualitative study with Phenomenological approach using in-depth interviews to explore the challenges that physically challenged women face in accessing skilled delivery services. The conclusion is based on the results and discussion of the study and presented as follows:

1. Knowledge of women with a disability on skilled delivery services was fairly high among disabled women in the study Tamale metropolis.
2. Patronage (75%) of skilled delivery services by physically challenged women in the Tamale metropolis was slightly low in view of the WHO standard of every woman in labour must be attended to or supervised by a skilled attendant who has been trained to provide quality services to mothers and babies during childbirth.
3. physically challenged women (83.4%) view skilled delivery services provided in health facilities as bad.
4. Negative staff attitude, cost of services, inadequate family support, the attitude of other health seekers and infrastructure not disability-friendly were the challenges physically challenged women faced in accessing skilled delivery services.
5. Inadequate staff, frequent shortages of basic delivery logistics, lack of separate facilities for physically challenged women, too much pressure from relatives, lack of special training of health workers to handle disabled women and lack of motivation; were the challenges midwives faced in providing skilled delivery services to physically challenged women.

6.4 Recommendations

The following recommendation emerged from the interview and the participants' own suggestions.

1. Ghana Health Service should institute specialized training for midwives to be able to understand the plight of physically challenged women.
2. The government should always make prompt payment of the health insurance claims so that the midwives will stop charging physically challenged women
3. The midwives should give their mobile numbers to physically challenged women during pregnancy so that when they are in labour they can quickly call for assistance.
4. Management of health facilities should create separate rooms and special climbing floor for physically challenged women in their facilities.
5. Ghana Health Service should ensure that health facilities stop issuing an exorbitant list of items for pregnant women to purchase in preparation toward delivery.
6. Ghana Health Service should intensify its campaign on the need for every pregnant woman, including physically challenged women in labour to be attended to or supervised by a skilled attendant who has been trained to provide quality services to mothers and babies during childbirth.
7. The government should provide every maternity unit with an ambulance to facilitate quick response to calls from women who get into labour at their homes.

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APPENDIX

DATA COLLECTION TOOLS

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH, DEPARTMENT OF PUBLIC HEALTH

INTERVIEW GUIDE (physically challenged women)

The challenges associated with patronage of skill delivery services by* physically challenged women *in the Tamale Metropolis

Introduction

Hello, my name is...

I am working on a project concerned with physically challenged women and skill delivery in which you could participate. The study is to explore the challenges that physically challenged women face in accessing skill delivery services. Gaining insight in these issues will help to improve health care access and quality to physically challenged women and your participation in this interview will contribute to reaching this goal.

The interview will take about one (1) hour. All the information I will obtain will remain strictly confidential and your answers and name will never be revealed. Also, you are not obliged to answer any question you do not want to, and you may stop the interview at any time. This is not to evaluate or criticize you, so please do not feel pressured to give a specific response and do not feel shy if you do not know the answer to a question. Feel free to answer questions at your own pace. We will be recording our discussion with a tape recorder because we may not remember everything that will be discussed. After this study the recorded information will be deleted.

Do you agree to participate in this interview? Yes ___ No ___

Do you have any question before I start? (*Answer questions, if any*).

May I start now? **Respondent Code: ....**

After the participant agrees to participate, I approach the participant with personal questions to build rapport.

SECTION A: Personal questions:

a. What were you just doing before we came?
b. Is that activity your hobby?
c. If no, then what is your hobby?
d. Do you join a community or negihbourhood activity on the weekend?
e. What do you do in your spare time?

SECTION B: Background

1. Now, can you please introduce yourself? ***Probe for (Age, Marital status, Educational level, Religion, Tribe, Number of children and Occupation)***
2. What type of disability do you have? ***Probe for (visual or physical impairment)***
3. What is the cause of your disability? ***Probe for (born with or accident. If accident, where and how?)***
4. Could you tell your experience living with disability? ***Probe for (how is it affecting your life? how it is affecting others' lives? How do you see other people living with disabilities?)***
5. Do you use aid? If the answer is Yes or No, could you explain why?
6. Could you tell me the support you get from your husband/partner and family? ***Probe for (How often do they accompany you to the hospital)***

SECTION C: Knowledge, Perception, Patronage and Challenges with regards to women with disability and skills delivery services

7. Could you tell me what you know about skills delivery services? ***Probe for (where did you hear of it, where it is provided, who provides it, who are the beneficiaries)***
8. During your last delivery, were you attended to by a skilled attendant? ***Probe for (where did you deliver? Why did you choose to deliver there? Who attended to you?)***
9. Could you tell us about your perception on skills delivery services provided to physically challenged women? **Probe for (whether it is good or bad, why good or bad)**
10. What Challenges did you face OR what challenges do physically challenged women face in assessing skills delivery services? **Probe for (personal challenges,**

societal challenges, affordability challenges, geographical challenges, health infrastructure challenges, health staff attitude)

11. In your personal view, what do you think could be done to improve upon skills delivery services for physically challenged women?

UNIVERSITY FOR DEVELOPMENT STUDIES
SCHOOL OF ALLIED HEALTH
DEPARTMENT OF PUBLIC HEALTH

INTERVIEW GUIDE (Health staff)

Exploring the challenges associated with patronage of skill delivery services by physically challenged women in the Tamale Metropolis

Introduction

Hello, my name is...

I am working on a project concerned with physically challenged women and skill delivery in which you could participate. The study is to explore the challenges that physically challenged women face in accessing skill delivery services. Gaining insight in these issues will help to improve health care access and quality to physically challenged women and your participation in this interview will contribute to reaching this goal.

The interview will take about 30 minutes. All the information I will obtain will remain strictly confidential and your answers and name will never be revealed. Also, you are not obliged to answer any question you do not want to, and you may stop the interview at any time. This is not to evaluate or criticize you, so please do not feel pressured to give a specific response and do not feel shy if you do not know the answer to a question. Feel free to answer questions at your own pace. We will be recording our discussion with a tape recorder because we may not remember everything that will be discussed. After this study the recorded information will be deleted.

Do you agree to participate in this interview? Yes ___ No ___

Do you have any question before I start? (*Answer questions, if any*).

May I start now? **Respondent Code: ....**

After the participant agrees to participate, build rapport and ask the following questions.

1. How long have you been working with GHS?
2. How long have you been working in this metropolis?
3. Have you heard of skilled delivery before? If yes, can you describe what you know about skilled delivery?
4. How long have you been providing delivery services?
5. Have you ever assisted a woman with physical disability or visual impairment to deliver**? Probe for (how often, how many natural delivery? How many CS,)**
6. How many women with physical disability or visual impairment delivered here during the last 12 months? (Use facility records, check age, marital status, condition of the women, number of times delivered)
7. These physically challenged women who delivered here, what support do they get from their husbands/partners or families. Probe for (how often they accompany them here)
8. In your view, how do women with physical disability or visual impairment perceive skilled delivery service provision in this facility? **Probe for (whether they perceive it as good or bad, why good or bad)**
9. You, as a service provider, what challenges do you think physically challenged women face in assessing skilled delivery services? **Probe for (personal challenges, societal challenges, affordability challenges, geographical challenges, health infrastructure challenges, health staff attitude)**
10. On your side as a provider, what challenges do you face/what challenges does health staff face in providing skilled delivery services to woman with physical disability or visual impairment? **Probe for** (**personal challenges, societal challenges, affordability challenges, geographical challenges, health infrastructure challenges, health staff attitude, Client attitude)**

11. In your personal view, what do you think could be done to improve upon skills delivery services for women with physical disability or visual impairment?

UNIVERSITY FOR DEVELOPMENT STUDIES
SCHOOL OF ALLIED HEALTH, DEPARTMENT OF PUBLIC HEALTH

INTERVIEW GUIDE (Husbands/Relatives)

Exploring the challenges associated with patronage of skill delivery services by* physically challenged women *in the Tamale Metropolis

Introduction

Hello, my name is...

I am working on a project concerned with physically challenged women and skill delivery in which you could participate. The study is to explore the challenges that physically challenged women face in accessing skill delivery services. Gaining insight in these issues will help to improve health care access and quality to physically challenged women and your participation in this interview will contribute to reaching this goal.

The interview will take about one (1) hour. All the information I will obtain will remain strictly confidential and your answers and name will never be revealed. Also, you are not obliged to answer any question you do not want to, and you may stop the interview at any time. This is not to evaluate or criticize you, so please do not feel pressured to give a specific response and do not feel shy if you do not know the answer to a question. Feel free to answer questions at your own pace. We will be recording our discussion with a tape recorder because we may not remember everything that will be discussed. After this study the recorded information will be deleted.

Do you agree to participate in this interview? Yes ___ No ___

Do you have any question before I start? (*Answer questions, if any*).

May I start now? **Respondent Code: ....**

After the participant agrees to participate, I approach the participant with personal questions to build rapport.

SECTION A: Personal questions:

a. What were you just doing before we came?
b. Is that activity your hobby?
c. If no, then what is your hobby?
d. Do you join a community or negihbourhood activity on the weekend?
e. What do you do in your spare time?

SECTION B: Background

1. Now, can you please introduce yourself? ***Probe for (Age, Marital status, Educational level, Religion, Tribe, Number of children and Occupation)***

2. What type of disability does your wife/relative have? ***Probe for (visual or physical impairment)***

3. What is the cause of the disability? ***Probe for (born with or accident. If accident, where and how?)***

4. Could you tell your experience living with your wife/relative with this disability? ***Probe for (how is it affecting your life? how it is affecting others' lives? How is it affecting the life of your wife/relative?)***

5, Could you tell me the support you give to your wife/relative with this condition?

SECTION C: Knowledge, Perception, Patronage and Challenges with regards to women with disability and skills delivery services

6. Could you tell me what you know about skills delivery services? ***Probe for (where did you hear of it, where it is provided, who provides it, who are the beneficiaries)***

7. Could you tell us about your perception on skills delivery services provided to physically challenged women? **Probe for (whether it is good or bad, why good or bad)**

8. What challenges do physically challenged women face in assessing skills delivery services? **Probe for (personal challenges, societal challenges, affordability challenges, geographical challenges, health infrastructure challenges, health staff attitude)**

9. In your personal view, what do you think could be done to improve upon skills delivery services for physically challenged women?