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ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY PERSONS WITH DISABILITIES: A CASE STUDY OF THE GARU –TEMPANE DISTRICT OF GHANA

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ISAAC TIIGA

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ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY PERSONS WITH DISABILITIES: A CASE STUDY OF THE GARU –TEMPANE DISTRICT OF GHANA

BY

ISAAC TIIGA (BA INTEGRATED DEVELOPMENT STUDIES)

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A THESIS SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

FEBRUARY, 2018

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DECLARATION

Student

I, **Isaac Tiiga,** hereby declare that this thesis work is the result of my own original research and that no part of this work has been presented for another degree in this University or elsewhere in Ghana and beyond.

Candidate's Signature: ---------------------------- Date -------------

Name:--

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Supervisor

I hereby declare that the preparation and presentation of this thesis work was duly supervised by me and that the work was supervised in accordance with the guidelines on the supervision of thesis work by the School of Allied Health Sciences of the University for Development Studies, Tamale.

Supervisor's Signature: ------------------- Date--------------

Name: ---

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ABSTRACT

The World Health Organization in 2009 extrapolates that 10% of the world's population representing 650 million people live with some form of disability. The Ghana Statistical Survey report in 2012 revealed that over 700 thousand people live with disability in Ghana. The findings of Groce in 2014 and the World Health Organization earlier in 2009 show that persons with disabilities in developing countries are plagued with limited access to sexual and reproductive health information and general health literacy. The situation of Ghana is a major concern in the face of limited research data on disability and access to services. In Northern Ghana poverty is endemic and persons with disabilities are among the poorest of the poor according to the 2014 Ghana Living Standard Survey report. Anecdotal evidence suggest that persons with disabilities constitute a significant number in Northern Ghana particularly in the study area ; yet no effort has been made to segment the disability population for effective delivery of services taking into cognizance their peculiarities. The main objective of the study was to investigate the access to sexual and reproductive health services by persons with disabilities in the Garu-Tempane District.

Data was collected using a combination of quantitative and qualitative methodologies. These included health facility observation, interviews with persons with disabilities exiting from reproductive health facilities, key informant interviews with service providers, focus group discussions with specific disability groups and the use of the mystery client approach to explore the attitudes of service providers and other service users. In all, 56 health facilities, 21 service providers and 141 persons with disabilities were contacted for data.

The study established that demographic variables such as age, gender, disability, marital status and religion influence the accessibility of reproductive health services by persons with disabilities in the study area. It was further discovered that access to reproductive health services by persons with disabilities were limited by systems factors including poor service delivery and lack of appropriate health services tailored to meet their needs. Also, economic, social and psychological factors were identified including lack of familial support, stigma and discrimination as barrier to access. Based on the findings, some recommendations have been proffered to improve the accessibility of reproductive health services by persons with disabilities.

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I thank my family especially my mother, Madam Grace Tiiga, my step mother, Madam Cecilia Tiiga, my siblings and above all my wife, Madam Mary Tiiga for their prayer support.

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DEDICATION

I dedicate this work to my late father, Mr. George Tiiga who inculcated in me the values of honesty, discipline and hard work. This work is also dedicated to persons with disabilities who are yearning to live lives of dignity amidst daunting challenges in Northern Ghana.

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LIST OF ABBREVIATIONS /ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome

ANC: Antenatal Care

CBR: Community Based Rehabilitation

CHAG: Christian Health Association of Ghana

CHPS: Community-based Health Planning Services

CRPD: Convention on the Rights of Persons with Disabilities

CSOs: Civil Society Organizations

CWDs: Children with Disabilities

DREDF: Disability Rights Education and Defense Fund

FGDs: Focus Group Discussions

FWCW: First World Conference on Women

GBU: Ghana Blind Union

GES: Ghana Education Service

GHS: Ghana Health Service

GNAD: Ghana National Association of the Deaf

GSPD: Ghana Society of the Physically Disabled

GSS: Ghana Statistical Service

HIV: Human Immunodeficiency Virus

ICIDH: International Classification of Impairment, Disability and Health

ICPD: International Conference on Population and Development

JHS: Junior High School

MDAs: Ministries Departments and Agencies

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MH-SHG: Mental Health Self-help Group

MOE: Ministry of Education

MOFA: Ministry of Food and Agriculture

MOH: Ministry of Health

NDA: National Disability Authority

NFED: Non-formal Education Division

NGOs: Non-governmental Organizations

OHCHR: Office of the United Nations High Commission for Human Rights

PHC: Population and Housing Census

PMTCT: Prevention of Mother to Child Transmission

PWDs: Persons with Disabilities

PWPD: Person with Physical Disability

RCN: Royal College of Nursing

SHGs: Self-Help Group

SPSS: Statistical Package for Social Scientist

SRH: Sexual and Reproductive Health

SRHS: Sexual and Reproductive Health Services

SRHR: Sexual and Reproductive Health and Rights

STIs: Sexually Transmitted Infections

TBA: Traditional Birthday Attendant

UN: United Nations

UNCRPD: United Nations Convention on the Rights of Persons with Disabilities

USAID: United States Agency for International Development

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UDS: University for Development Studies

WHO: World Health Organization

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DEFINITION OF TERMS

Abortion: The deliberate termination of a pregnancy, usually before the embryo or fetus is capable of independent life.

Antenatal care: The routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery.

Contraception: The deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse.

Disability: Any restriction or lack of the ability to perform an activity within a range considered normal for a human being.

Family Planning: The practice of controlling the number of children one has and the intervals between their births, particularly by means of contraception or voluntary sterilization.

Impairment: Any loss or abnormality of physiological, psychological, or anatomical structure or function, whether permanent or temporary.

Reproductive Health: A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

Unmet need for family planning: It is the percentage of women of reproductive age, either married or in a union, who want to stop or delay childbearing but are not using any method of contraception.

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CHAPTER ONE

BACKGROUND OF THE STUDY

1.0 Introduction

This chapter entails the background of the study and briefly discusses basic issues of disability and access to reproductive health, problem statement, research objectives and questions as well as the theoretical or conceptual model underpinning the study.

1.1 Background

The research findings of World Bank reveal that all over the world, "Persons with disabilities, on average as a group, are more likely to experience adverse socioeconomic outcomes than persons without disabilities, such as less education, worse health outcomes, less employment, and higher poverty rates" (World Bank, September, 2015).

The findings of Groce in 2014 and the World Health Organization earlier in 2009 show that persons with disabilities in developing countries are faced with limited access to sexual and reproductive health information and general health literacy (Groce,2014; WHO,2009)

Studies show that close to 70% of persons with disabilities live in rural areas in Ghana and suffer from poverty, discrimination and social exclusion (VODEC, 2015).

The Ghana Living Standard Survey report in 2014 identifies Northern Ghana as a poverty endemic area with persons with disabilities being among the poorest of the poor (GLSS, 2014).

A socio-economic survey conducted in the study area by the Garu-Tempane District Assembly established that close to 60% of the district's population-a medley of ethnic

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crowd live below the poverty line (GTDA, 2015). Some of these (an estimated 10%) are peasant farmers with disability who continue to record poor yields due to poor rainfall patterns and unemployed persons with disabilities ,especially the youth who lack employable skills (GTDA,2015).

In 2012, the Ghana Statistical Service established that the Northern Ghana recorded the highest maternal mortality ratio in the country (an estimated 802 per 100,000 live births in the Upper East Region, the highest nationwide and 531 per 100,000 live births in the Northern Region) (GSS, 2012).

The CBR Annual Report in 2014 suggests that unintended pregnancies, unsafe abortion practices and maternal deaths are common among PWDs in the Garu –Tempane District (CBR, 2014).

Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes (ICPD, 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."(WHO, 2010). Persons living with disabilities are known to be among the poorest of the poor who often have difficulty meeting their basic

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needs, including family planning needs and this makes them more vulnerable (World Bank, 2004).

Individuals are plagued with inequalities in reproductive health services. Inequalities differ based on socioeconomic status, educational level, age, ethnicity, religion and resource availability (KS Hall et al., 2012).

Studies show that access to reproductive health services is poor in many countries. Women are often unable to access maternal health services due to lack of knowledge about the existence of such services or lack of freedom of movement. Some women are subjected to forced pregnancies and banned from leaving the home and as their autonomy is limited, their ability to access medical services are limited (Steve et al., 1999). According to the World Health Organization, all women need access to antenatal care in pregnancy, skilled delivery during childbirth, and care and support in the weeks after birth (WHO, 2016)

Access to quality family planning services can significantly reduce abortions. Research in various countries demonstrates that women with access to good family planning services are more likely to use contraception, are less likely to have unintended pregnancies, and thus have fewer abortions. Where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises (WHO, USAID, 2008). However, available evidence suggests that in Ghana, the hearing/speech impaired face numerous challenges in accessing and utilizing essential health services and this affects their quality of life (MPRA, 2013).

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1.2 Problem statement

Quite a huge number; an estimated 10% of the world's population (650 million people) live with some form of disability (WHO, 2009).

In Ghana, about 3 % of the total population, constituting 737,743 persons lives with some form of disability (GSS, 2012). Out of this, females with disabilities constitute about 52.5% whilst males with disabilities are 47.5%.

The Upper East Region of Ghana, where this study was conducted has a disability prevalence of 3.8%, the second highest after the Volta Region (GSS, 2012).

There is limited comprehensive data on disability in northern Ghana more particularly in the study area. Anecdotal evidence suggests that about 3% of the total population of the Garu-Tempane District are persons with disabilities (GTDA,2013).This is however not disaggregated in terms of age, sex and other population parameters, making it less reliable. However, in 2015 the CBR established a total of 550 PWDs in the Garu-Tempane District through community surveys, 51 of which fell within the active reproductive age brackets (CBR, 2015).One major challenge for health service delivery in the District is that there is no segregation of the population in relation to population peculiarities for effective services. Diverse population groups are lumped up and seen as same.

According to the UNCRPD, and other International Human Rights Conventions, health is a basic universal right for all. This includes Sexual and Reproductive Health (SRH) (WHO, 2009). PWDs have the same sexual and reproductive health needs as other people without disabilities (Mprah, 2013).

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Available information indicates that PWDs in developing countries have limited access to SRH Education and general health literacy (Groce, 2004; WHO, 2009).

Study findings indicate that when accessing SRH information and services in Ghana, deaf people encounter numerous barriers such as problems with communication, ignorance about deafness, negative attitudes, and services that are not customised to their needs (Mprah, 2013). Findings about other categories of PWDs other than the deaf such as the visually, physically and mentally challenged regarding SRH have not been established.

Unintended pregnancies have been identified to be common among the youth with disabilities in the Garu –Tempane District and this serves as an obstacle to their rehabilitation process (CBR, 2014). There exist a number of health facilities (both public and private) in the Garu-Tempane District that render SRH services but no study has been done on how inclusive their services are to PWDs neither have there been any investigation to establish barriers that inhibit PWDs from accessing SRH services.

This study therefore sought to investigate the access to SRH services notably, family planning, contraception, abortion, antenatal care and HIV/AIDS among PWDs (Hearing/speech impaired, visually impaired, physically challenged and mentally handicap) in the Garu-Tempane District of Ghana.

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1.3 Research objectives

Main objective:

To investigate the access to sexual and reproductive health services by PWDs in the Garu-Tempane District.

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Specific objectives:

1. Assess service accessibility for PWDs at SRH Service outlets
2. Assess the knowledge, attitudes and practices (KAPs) regarding SRH services
3. To examine the level of satisfaction of PWDs with regards to the kind of SRH services offered them by service providers.
4. To assess economic and other factors that restricts access of PWDs to SRH services.

1.4 Research questions

1. How accessible are SRH service facilities/outlets to persons with disabilities?
2. Do service providers have any knowledge about disability and how do they handle disability issues and need?
3. What are the perceptions of persons with disabilities/stakeholders regarding the availability and quality of SRH services delivered by service providers?
4. What economic and other factors influence the health seeking behaviour of PWDs towards SRH services?

1.5 Significance of the study

There is limited research on disability throughout Ghana. Therefore the study contributed significantly in making information on disability available. The information established is needed to inform public policy on disability especially as it relates to the formulation of policies geared towards the empowerment of PWDs and promoting disability mainstreaming to ensure inclusive development. The findings can help planners and policy makers in identifying the necessary areas of intervention in a quest to help PWDs

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access sexual and reproductive health services in Ghana. The study indicates the social, cultural, economic, physical and medical issues that affect accessibility of SRHS by PWDs in the Garu-Tempane District of Northern Ghana. The findings are based on the experiences and views of PWDs, health workers and key informants in the health care delivery system. Their perspectives provide vital information for policymakers, health workers, donors and communities on how to improve access to health care generally, and how to support PWDs to access vital services such as ANC, Family Planning, contraceptives and safe abortion practices to promote inclusive health and wellbeing. In other words, the findings established by the research can be used to engender or trigger relevant actions by key actors and stakeholders to promote maternal and child health as well as SRH generally for PWDs and non-PWDs in Ghana and beyond.

The work has also contributed to useful knowledge in the field of academia.

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1.6 Scope of study

The study focused on challenges confronting PWDs in accessing sexual and reproductive health services. This took into cognizance the assessment of physical accessibility of services, social barriers or factors related to knowledge, attitudes and practices, economic barriers and other factors influencing access within the study context.

1.7 Structure of thesis

This report or document is organized in six (6) chapters. Chapter one (1) entails the study background and briefly outlines basic issues of disability and access to reproductive health, problem statement, research objectives and questions, the scope, structure and relevance of the study as well as the theoretical or conceptual model underpinning the study.

Chapter two (2) contains the review of relevant literature which is centred mainly on research work related to disability and components of sexual and reproductive health services such as Family Planning, Contraception, Abortion, HIV/AIDS, Antenatal Care and the associated issues that bother on service accessibility.

Chapter three (3) describes the methodology adopted for the study, which includes data collection methods, sampling procedures and techniques, data analysis procedures, ethical considerations and limitations of the study.

Chapter four (4) deals with data presentation and analysis whilst Chapter five (5) focuses on the discussion of study findings.

Chapter six (6) focuses on the synopsis of the key findings, conclusions and recommendations aimed at improving SRH service accessibility to PWDs.

1.8 Conceptual model

The study draws its theoretical underpinnings from the social learning theory. In the words of its main architect, Albert Bandura, "Social learning theory approaches the explanation of human behavior in terms of a continuous reciprocal interaction between cognitive, behavioral, and environmental determinants"(Social Learning Theory, 1977).It indicates three-way reciprocal relationship that influences human behavior. The researcher anchored the study on three factors namely physical, economic and social that interacts to determine accessibility of sexual and reproductive health services to PWDs. In other words, the interplay of three main factors notably physical, economic and social defines the barriers of accessibility of SRHS as in the diagram below:

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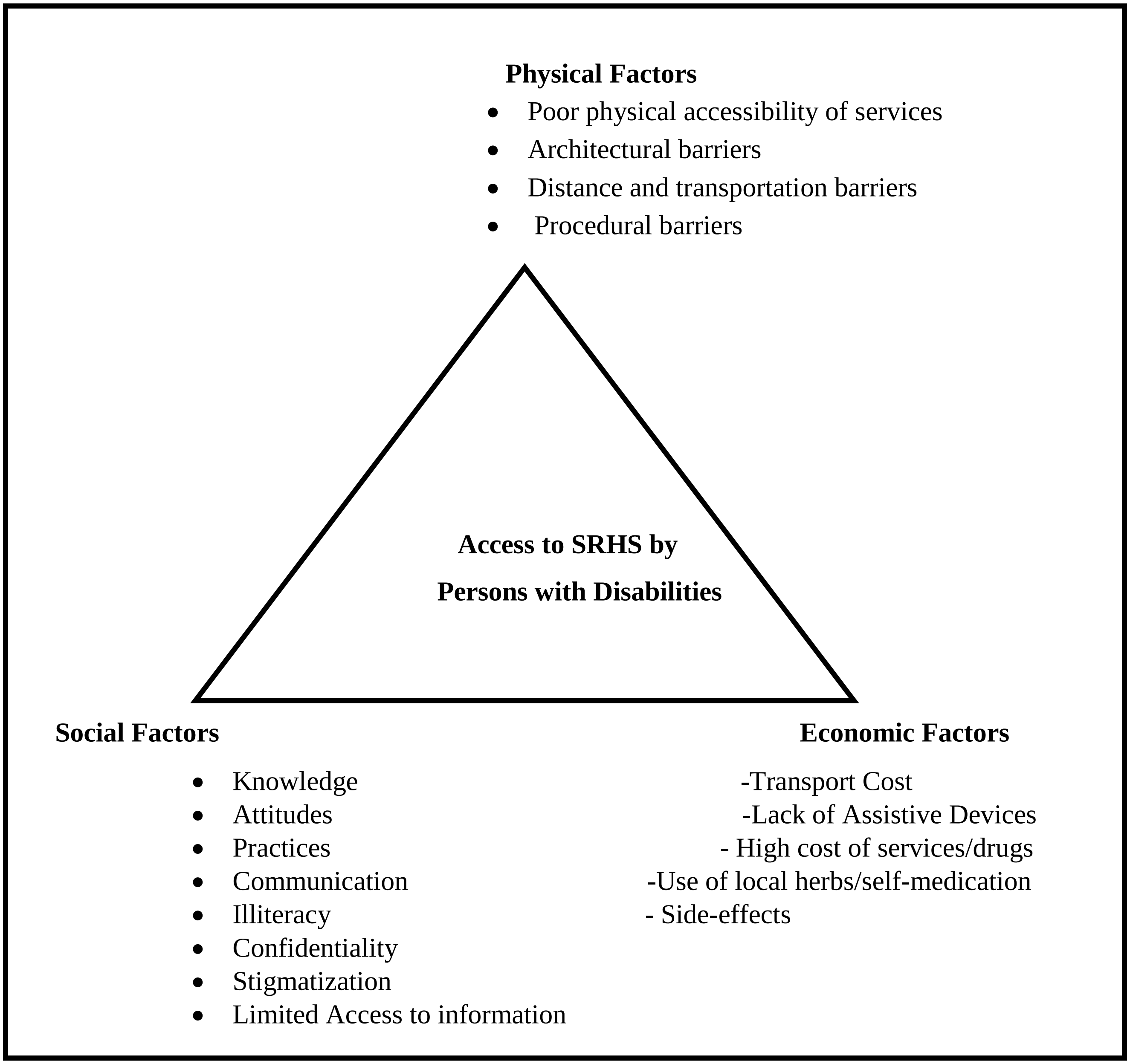

Figure 1.1: Factors Influencing the Accessibility of Sexual and Reproductive Health Services to Persons with Disabilities.
Source: Albert Bandura (1997) Social Learning Theory.

From Figure 1.1, physical factors related to poor physical accessibility of services and service outlets, unfriendly architectural designs, distances to be covered before reaching service facilities, transportation barriers and procedural barriers impede accessibility of sexual and reproductive health services to persons with disabilities. Physical accessibility is measured by service availability and the geographic distribution or allocation of services in space. The distance dimension of service access is a function of service distribution through space and PWDs are less likely to go for SRHS if the facilities are physically remote from where they reside. Besides, in some places, the absence of reliable means of transport for PWDs to travel to service points serves as an impediment to service access. Moreover, the infrastructure at SRH outlets lack provisions such as ramps, hand railings, pavements among others for people with disabilities especially those with physical impairments such as wheelchair users and these make such facilities inaccessible .These coupled with the rather cumbersome procedures and processes that must be followed within health facilities before accessing SRHS from the service providers may turn to frustrate and discourage PWDs from utilizing such services.

Furthermore, Social factors related to knowledge, attitudes and practices influence accessibility of SRHS to PWDs. The knowledge of service providers about disability issues on one hand could inform the treatment they mete out to PWDs seeking their services; the knowledge of PWDs about the availability of existing SRH services on the other hand may inform their decision to utilize those services. Negative social attitudes exhibited by both service providers and other services users to PWDs at service delivery points may serve as an obstacle to service utilization by PWDs. The stigma exhibited towards PWDs at service outlets may generally scare them from utilization of services. The inability of service providers to effectively communicate with PWDs especially those with hearing/speech impairments through sign language to ensure maximum confidentiality may compromise the quality of services they render to PWDs and may lead to PWDs being dissatisfied. Also, illiteracy on the part of PWDs to able to read

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posters, brochures and any information on SRH may negatively affect their utilization of available services. Again, the failure to package SRH information in appropriate formats such as large prints, braille among others may limit the ability of the visually impaired to utilize such information and this may ultimately affect their usage of services.

Economic accessibility defined as the ability to pay for services or afford services is a key determinant of service utilization. High cost of services may limit the ability of PWDs to access such services. In other words, the availability of SRH services may not necessarily guarantee access unless they are affordable. Economic factors related to the ability of PWDs to afford means of transport to service delivery points or acquire assistive devices to facilitate their mobility to service outlets may affect their access to SRH services. Again, the lack of basic disability friendly assistive devices at service delivery points to support the movement of the physically challenged persons may discourage them from visiting health facilities for services. Besides, the side effects that come with the use of some SRH services like family planning methods and abortion may deepen the economic demand on PWDs to deal with such side-effects medically. In view of the economic considerations, PWDs may resort to the use local herbs or self-medication as an alternative care but these may have worse consequences on their health.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews the literature focusing on the definition of disability, and key aspects of sexual and reproductive health of this cohort. In this regard, research work related to disability and components of sexual and reproductive health services namely: Family Planning, Contraception, Abortion, HIV/AIDS, Antenatal Care and the associated issues that bother on access to these services will be discussed.

2.1 Conceptualization of Disability and Unmet Need of Family Planning.

Disability refers to any form of restriction or lack of the ability to perform an activity within a range considered normal for a human being. A person with disability is an individual who is recognized by society as being handicapped in view of differences in appearance, behaviour, communication and functional limitation. Disability may be temporary or permanent and reversible or irreversible and be may described as progressive or regressive (Sally Hartley, 2001).

Disability is the consequence of an impairment that may be physical, cognitive, mental, or some combination of these. Disability may be present from birth, or occur during a person's lifetime. According to the International Classification of Impairment, Disability and Health (ICIDH-2), a person's functioning and disability is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors. Contextual factors include both personal and environmental factors. All persons, both adults and children are prune to disability (WHO, 2001).

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Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions (WHO, 2011).

Evidence Suggests that about 650 Million of the World's population live with some form of disability (WHO, 2009).

In Ghana it has been established that there are 737,743 persons who live with some form of disability, representing 3.0 percent of the total population. The data also show that there are more females (52.5%) than males (47.5%) with some form of disability (GSS, 2012).

The regional distribution of disability indicates that the Volta region (4.3%) has the highest proportion of population with disability, followed by Upper East (3.8%). BrongAhafo (2.3%) has the lowest proportion of persons with disability (GSS, 2012).

Evidence points out that in Ghana, visual or sight impairment (40.1%) is the most common disability, followed by physical challenges (25.4%), emotional/behavioural problems (18.6%), intellectual malfunctioning (15.2%) and hearing (15%) (GSS, 2012).

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) guarantees PWDs the right to access health provided to other persons, including sexual and reproductive health (WHO, 2009).

Not meeting the need for family planning, combined with the occasional failure of contraceptive methods, causes millions of unintended pregnancies each year in sub-Saharan Africa. Unintended pregnancies (accounting for about 30% of all births in sub-Saharan Africa) result in either abortion or births, both of which can have severe health consequences .The risk of abortion-related death is four times greater for an African

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woman than for an Asian woman, and 650 times greater than for a North American woman (WHO, USAID, 2008).

Demographers and health professionals use the term “unmet need” to indicate the number or percentage of married women who say they prefer to avoid a pregnancy but are not using any method of contraception. Research confirms high unmet need for family planning among African women, whether for spacing births or limiting childbearing (WHO, USAID, 2008). The case of women with disabilities is most likely to be worse as they are generally known to be more vulnerable and poor.

Some women who do not want to become pregnant but do not use contraception may resort to abortion whether it is legal or not. But the associated risks are high in developing countries, as demonstrated by these key facts: Most abortions in developing countries are unsafe because they are performed in unsanitary conditions or by unskilled providers, or both, which can cause death or long-term disabilities. Unsafe abortions account for 13% of all maternal deaths globally, and African women have the highest risk of abortion-related deaths in the world (WHO, USAID 2008).

The factors associated with the failure to meet the family planning need vary from country to country. While access to affordable modern methods of contraception is sometimes a problem, other reasons for the non-patronage of family planning practices do exist.

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2.2 Human Rights and the Sexual and Reproductive Rights of Persons with Disability

There has been an increasing focus on human rights in recent years. In 1994, the International Conference on Population and Development (ICPD, 1994) in Cairo was the

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first international agreement to focus on universal access to sexual and reproductive health services without discrimination on the basis of age, civil status, or any other condition. Both the Cairo and Beijing conferences recognized that realization of the rights of women and men to the highest attainable standard of sexual and reproductive health is central to any social development policy. Within this context, the specific needs of adolescents and other marginalized groups were seriously articulated within a human rights framework (ICPD, 1994). Thus, reproductive rights and, implicitly, sexual rights were recognized for all persons.

The importance of sexual and reproductive health rights was also reaffirmed at the 1995 Fourth World Conference on Women (FWCW) held in Beijing. Confirming the objectives of ICPD, FWCW+5 also notes that access to sexual and reproductive health information, education, and services is still limited and that adolescents' rights are generally not respected (UN, 2000). Series of measures are laid out in the FWCW+5 resolutions for governments, civil society, and cooperating organizations.

Over the years, the scourge of sexually transmitted diseases including HIV/AIDS has stimulated a tremendous increase in the concern for the sexual and reproductive health and welfare of people generally. Data suggest that people are vulnerable in sexual encounters if it is unprotected because it could place them at risk. Unprotected sex exposes people to special problems that are both medical and psychosocial. The dangers of sexually transmitted diseases (including HIV/AIDS) are dramatically on the increase among especially young people including those with disabilities in Ghana (GAC, 2007). Ignorance and fear may contribute to a lack of recognition and treatment of such health

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problems, with devastating consequences for the person. Overall, young people are at high risk for sexual health problems and their adverse consequences (Groce, 2004).

Unfortunately however, the records suggest that sexual and reproductive health services are hardly accessible to this segment of the population (Groce, 2004). Even where available, sexual and reproductive health programmes hardly include all segments of the youth population. Three categories in particular often inadvertently excluded in the development process are: out-of-school youth (especially street children), married adolescents and adolescents with disabilities. In respect of the three categories, adolescents with disabilities are the most neglected. Indeed given the UN resolutions underlining the fact that generally adolescent sexual and reproductive health care needs are not being adequately met, it is obvious that by implication, the most marginalized segment of this population (adolescents with disabilities) are much neglected. Generally, disabled people are among the poorest of the poor, most marginalized and most stigmatized of all the world's citizens (World Bank, 2004).

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In line with this grave situation, hundreds of millions of Persons with Disabilities (PWDs) do not have access to the opportunities and resources to fulfill their basic sexual health needs (World Bank, 2004). Even though the records suggest that PWDs are often overlooked in sexual and reproductive health interventions generally, it is important to note that adolescent persons with disabilities - as a subset of the adolescent population - are consequently the most vulnerable. The situation is in part because the sexual health needs of this population are not clearly understood within the social and cultural context of their lives, but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality – and that of adolescents with disabilities or hold uncompromising attitudes toward adolescent sexual behaviour- and certainly more towards that of adolescents with disabilities (Guttamacher, 2015).

As noted by the World Bank (2004), too often, individuals with disability have not been included in sexual health outreach efforts *"…because it is assumed that they are not sexually active and at little or no risk for … infection".* Current research shows however that many youth – including adolescents with disabilities - are sexually active. The records also show that often and by a variety of means, adolescents with disabilities are pressured to have sexual relations that they may not want (Bennett et al., 2000). The experts warn that nonconsensual sex may underlie some of the most tenacious and often life-threatening reproductive health problems among young people generally and worse with adolescents with disabilities (Bennett, 2000).

The Convention on the Rights of Persons with Disabilities in 2006 brought the need for greater protection and promotion of the rights and dignity of persons with disabilities in sharp public focus (UN, 2006). The Convention emphasizes the perception of disability as primarily a social problem and a human rights issue which demands a social and political response. This makes it critical for policies and programmes to improve the sexual and reproductive health of this segment of the population (OHCHR, 2007).

It is obvious however that research on the sexual and reproductive health of PWDs generally is very scarce. The recent Global Survey on Disability and HIV/AIDS conducted by the World Bank and Yale University (2004) has served a major pioneering role. The findings have debunked the common assumption that persons with physical, sensory or intellectual disabilities are not at risk of HIV infection. Persons with Disabilities are often inadvertently thought to be sexually inactive, unlikely to use drugs,

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and at less risk for violence or rape than their non-disabled peers. But research findings generally show that men and women with disabilities are even more likely to be victims of violence or rape, although they are less likely to be able to obtain police intervention, legal protection or prophylactic care (Groce and Trasi/World Bank, 2004).

In an article on “HIV and people with disability”, Groce (2003) observed that there are significant risk factors for disabled populations around the globe. She noted that those with disability – and disabled women in particular – are likely to have more sexual partners than non-disabled peers. It is obvious that given the extreme poverty and social sanctions against marrying a disabled person in most societies, this segment of the population are more likely to become involved in a series of unstable relationships. Factors such as increased physical vulnerability, the need for attendant care, life in institutions, and the almost universal belief that disabled people cannot be a reliable witness on their own behalf makes them targets of predators. In addition, assumed to be virgins, PWDs have also repeatedly become targets of rape in cultures in which it is believed that HIV-positive individuals can rid themselves of the virus by having sex with virgins (Groce, 2003).

Studies point out that persons with disabilities are at increased risk of HIV infection and are less likely to access HIV prevention, care and treatment services than their non-disabled counterparts due to low levels of HIV/AIDS awareness, vulnerability to sexual abuse, ignorance or discriminatory attitudes among health workers and educators, inaccessible service facilities, and lack of institutional and human capacity of the disability movement to address HIV/AIDS (NUDIPU, 2004). Preventing unintended pregnancy among HIV-positive women is both a way to meet this vulnerable

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population's reproductive health needs and an effective approach to prevent mother-to-child transmission of the disease. HIV-infected women who wish to avoid pregnancy must have ready access to family planning. However, a review of PMTCT programs found that implementers have not placed a priority on family planning, thus missing an important opportunity to respond to HIV-infected women's needs (WHO, USAID, 2008). The situation of Women with disabilities who are infected with HIV/AIDS could be worse due to the stigma attached to both disability and HIV/AIDS (NUDIPU, 2004).

Recent evidence shows that people with HIV infection can safely use more types of contraceptive methods than was previously thought. For example, most women with HIV infection can use intrauterine devices and take hormonal contraceptives while on antiretroviral therapy (WHO, USAID, 2008). Nonetheless, Available information indicates that PWDs in developing countries have limited access to SRH Education and general health literacy (Groce, 2004, WHO, 2009).

Obviously since PWDs make up to 10 percent of the global population, their very numbers is simply too large to ignore. Acceptably, their continued exclusion runs the risk of hampering efforts to bring sexual health to all. Data suggest that as many as 600 million people worldwide live with a physical, sensory (deafness, blindness), intellectual, or mental health impairment significant enough to make a difference in their daily lives (UN, 1993). Eighty percent of these live in the developing world with a larger proportion in rural rather than urban areas (Helander, 1999). Disability also significantly impacts the lives of disabled people's family members and communities. Together they form a substantial proportion of the world's poor.

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2.3 Access of PWDs to sexual health care programmes

Access to health care refers to the ability to obtain and the actual receipt of health care (Aday and Andersen, 1984). It encompasses more than just access to the physical environment; it also includes access to health information and effective communication between health professionals and women. Women with disabilities report insufficient access to health care services (Fouts et al., 2000). They encounter substantial challenges, which impact significantly on their ability to access care. These challenges are varied and can be categorised as physical, attitudinal, communicational, informational and financial (Thierry, 1998). Parish and Huh conclude that access to health is the 'timely utilisation of services to achieve the best possible health' (Parish and Huh, 2006:pp. 7).

Access to health care is the ability to obtain health services when needed. This includes access to sexual and reproductive health (SRH) which forms an integral part of the health care system. According to Bodenheimer (2002), access to health care has to do with two major components namely: the ability to pay (economic accessibility) and the availability of health care personnel/facilities that are close to where people live (physical accessibility) which includes issues of accessible transportation, cultural acceptability, timely provision of care and language/communication.

The United Nations Convention on the Rights of Persons with Disabilities and other international human rights protocols guarantee the fundamental human rights to physical, social and psychological health. The UN Convention on the Rights of Persons with Disabilities guarantees persons with disabilities the right to access "the same range, quality and standard of free or affordable health care and programs as provided to other persons, including those in the area of sexual and reproductive health and population-based public health programs" (UN,2006). However, available evidence suggests that persons with disabilities (PWDs) still face numerous challenges in accessing and utilizing essential health services and this affects their quality of life. Impediments to receiving the required health services include attitudinal biases of health and social service providers, physical barriers in clinical settings, and poor dissemination of information. Persons with disabilities also experience lack of privacy and respect by health interventions in addition to various aspects of their care needs not being acknowledged (Ahumuza et al., 2007).

A disability rights activist, Werner (1998) in his book entitled "Nothing about us without us" advocates for "a sound society for all". People living with disabilities have special needs and the access to services to meet such needs can be enhanced when PWDs themselves are involved in designing and defining programmes and services that reflect such needs. This special needs include the area of SRH.

According to the Disability Rights Education and Defense Fund, the ongoing gap between legal theory and on-the-ground practice results in people with disabilities being far more likely to receive a range of poor responses when seeking healthcare, from outright denial of care to inadequate care to bad treatment. The problem behind these responses can be rooted in the existence of physical or procedural barriers, the holding of stereotypes and ignorance about people with disabilities, and actual hostility and prejudice (DREDF, 2007).

It is to improve the well-being of this group that the provisions of the Ghana Disability Act (Act 715 of 2006) seek to enhance service accessibility to PWDs without discounting sexual and reproductive health services. However, Mprah (2013) contends for example

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that in Ghana the deaf in an attempt to access services encounter multiple barriers such as problems with communication, ignorance about deafness, negative attitudes and services that do not customize their needs.

The situation is however not peculiar to Ghana. Michael Ulrich pointed out that Medicare and Medicaid were passed in the United States of America to serve as safety nets for the country's most vulnerable populations, a point that has been reemphasized by the expansion of the populations they serve, especially with regards to Medicaid. Yet, even after 50 years, the disabled population continues to be one whose health care needs are not being met. He observed that the disability community is all too frequently left to suffer health disparities due to cultural incompetency, stigma and misunderstanding, and an inability to create policy changes that cover the population as a whole and their acute and long-term needs (Ulrich , 2014).

It is within this context that Massie (2006) - the Chairperson of the UK Disability Rights Commission - stated in a disability conference in Dublin: "*Attitudes to disability are the major barrier to disabled peoples' full participation…From pity, awkwardness and fear, to low expectations about what disabled people can contribute, stereotypical and negative attitudes hold people back"*(Massie, 2006). It has been observed that "*People with disabilities regularly identify societal attitudes as the most potent and negative stressor in their lives…*" (Voh, 1993).

In Ghana, the records suggest that the lack of self-reliant living is the result of several factors, including appropriate and low cost aids/equipment coupled with less welcoming acceptance from the general public which acts as barrier to social integration (Alo,

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1998).In as much as negative attitudes persist, the full rightful acceptance of people with disabilities is unlikely (Nowicki, 2006 citing Antonak et al., 2000). Recognizing that persons with disabilities are still exposed to and oppressed by prejudice and discrimination may be the first step in reducing prejudice (Genesi 2007 citing Marks, 1997).

Shapiro (2000) in '*Everybody Belongs'* dilates on how negative myths and stereotypes continue to create ingrained prejudices towards people with disabilities. According to him, prejudices are reflected in negative attitudes and behaviour, which can impede the participation of people with disabilities in social, educational and vocational contexts (White et al., 2006 citing Rao, 2004; Rubin et al, 1995; Rusch et al., 1995). Swain et al (1993) review the extensive range of barriers faced by people with disabilities. These in general show why many are deprived and remain largely the poorest of the poor. In the same vein, Rosenthal et al. (2006) cite studies including Smart (2002) that clearly indicate how negative social attitudes impede the integration of people with disabilities into society.

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Stereotypes about this group remain one principal factor that ferments negative societal attitudes generally. Chen (2002) made references to other research works that shows the effects of negative societal attitudes in preventing individuals with disabilities from "mainstreaming into society". These include Arokiasamy et al. (2001), De Loach (1994), Moore et al. (1999), Orange (2002) and Yuker (1994, 1995). Deal (2006) for instance, cites studies that demonstrate that attitudes towards people with disabilities are predominantly negative. Other researchers including DuBrow (1965), English et al.

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(1971), Florian et al. (1987), Gething (1991), Lee and Rodda (1994), Fries (1997), Stiker (1997) and Christie et al (2000) made similar observations.

Societal attitudes also influence social policy and legislation.It has been argued that public attitudes dictate, to a large extent, social policy (Hewes et al., 1998 citing Hahn, 1985). Negative public attitudes can be an invincible barrier to the success of particular policies because the public significantly influences how much importance is given to an issue. Massie (2006) observes that in the case of people with disabilities, this is made worse by the fact that "disabled people are under-represented in the public sector, particularly in strategic and management positions. They are under-represented where decisions about policy and service provision are taken". In England for example, Deal (2006) examined attitudes of people with and without disabilities towards other people with disabilities and to different impairment groups. The results were similar and attitudes of both groups fell within the positive threshold of the scale indicating positive attitudes to disability. However, when measured by a subtle prejudice sub-scale of the instrument used people with and without disabilities produced more negative attitudes. This suggests that people may often hold subtle forms of prejudice towards disability that may not be detected when using more direct methods that allow respondents to respond in ways they consider more socially appropriate.

Accepted ways of thinking, reacting and doing business become firmly embedded in society and can be remarkably resistant to change. Negative attitudes can become institutionalized. Massie (2006) observes that "*We often see the impact of negative attitudes in how one person treats another. But negative attitudes are also the foundation stone on which disabling policies and services are built. Harmful attitudes that limit and* *restrict are institutionalized in policies and services and so maintain the historic disadvantage that disabled people have faced"*. Biklen (1987) is of the opinion that a major reason for negative social attitudes, resulting in the denial of basic values and rights/conditions, is the way disability is portrayed and interpreted in society. In the same vein, Taylor et al. (1993) identified social construction of disability as a barrier to social inclusion. At community level, negative attitudes can become structured into social patterns of segregation and discrimination.

The theory of social construction attempts to explain the process by which knowledge is created and assumed as reality (Douglas, 1970 cited by Devine, 1997). The theory asserts that meanings are created, learned and shared by people and then reflected in their behaviour, attitudes and language (Devine 1997 citing Berger et al.,1966).Particular social constructions of disability portray people with disabilities as "other" and not as an integral part of the 'normal' world. Negative attitudes and behaviours develop from this 'worldview'.

In the last two decades disability rights activists and academics have highlighted cultural and environmental factors that marginalize people with disabilities, denying them basic values and the accompanying basic rights/conditions. This social model of disability places a person's impairment in the context of social and environmental factors, which create disabling barriers to participation (Oliver, 1990).This social model of disability approach suggests that the root of disability lies in a failure of the environment to allow someone to function to his/her full capacity as much as in any functional impairment that the person may have.

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Crow (1996) observes that explaining the marginalization of people with disabilities through cultural and environmental factors does not mean that impairment is denied. Impairment is an objective concept and means that aspects of a person's body do not function or function with difficulty. However, when impairment is taken a step further to imply that a person's body, the person and the person's worth is inferior to that of others, then there is an interpretation that is socially created and is therefore not fixed or inevitable (Crow, 1996). Crow argues that one can think of impairment in three, related, ways. First there is the objective concept of impairment. Second, there is the individual interpretation of the subjective experience of impairment. Finally, there is the impact of the wider social context upon impairment in which misrepresentation, exclusion and discrimination combine to disable people with impairments. It is this third aspect of impairment which is not inevitable. Such socially constructed interpretations and meanings are not fixed or inevitable and can therefore be replaced with alternative interpretations (Crow, 1996).

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The situation is even worse for young people generally but more for young people with disability. Bender (2013) explored barriers to sexual and reproductive health services as perceived by young people and established that barriers exist and these impair access to and utilization of SRH services. He observed that in order to make SRH services more appealing to young people, those barriers to services need to be recognized and reduced. In order to reach everyone in society, service providers need to take into consideration the peculiar needs of the diverse group of people including people with disability. Furthermore, Ong et al. (2012) argues that strategies for improving consistency of effective contraception use or greater emphasis on long-acting contraception may be

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needed for certain sub-populations at higher risk for unintended pregnancy. Access to services for example is a central concern surrounding the promotion of sexual and reproductive health and rights (SRHR) of young people generally and for young people with disability especially. A more holistic ('positive') approach toward SRH is needed, as is the provision of services that tackle sexual and gender based violence, sexual diversity, discrimination, relationship issues, and fears and concerns about sex and sexuality (Braeken, 2012).

Another important factor in the equation is the issue of quality of care including the attitude of service providers. Interpersonal relations between health care providers and clients especially the vulnerable including young people and people with disabilities have long been cited as an important element for improving client up take of services, satisfaction and overall health outcomes. In an era of HIV and AIDS, interpersonal relations form a critical determinant to accessing sexual and reproductive health care especially by the vulnerable in society (Alli, Maharaj, Vawda, 2013).

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Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in Sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57.4% in 2014 (Kehinde, 2013).Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2014. In Africa it went from 23.6% to 27.6%, in Asia it has risen slightly from 60.9% to 61.6%, and in Latin America and the Caribbean it rose slightly from 66.7% to 67.0%.

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In terms of sex, females are more likely to be users of contraceptives than men. Thus the use of contraception by men makes up a relatively small subset of the above prevalence rates. This may also be due to the fact that modern contraceptive methods for men are limited to male condoms and sterilization (vasectomy). It is important to note that an estimated 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include: limited choice of methods; limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people; fear or experience of side-effects; cultural or religious opposition; poor quality of available services; users and providers bias and gender-based barriers.

The unmet need for contraception remains quite high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 23.2% of women of reproductive age have an unmet need for modern contraception (WHO, 2013)**.**

Studies indicate that married adolescents in certain parts of the world like in Latin America and the Carribean make use of contraception than the unmarried and that the unmarried are less likely to go for contraception due to infrequent sex and the stigma that they have to face when seeking contraception (Guttamacher, 2015). For adolescents with disabilities in the study area, this challenge could even be worse in the face of limited research evidence.

Also, religious factors have been discovered to have an influence in the utilization of contraception in certain parts of the world. A study conducted in Nigeria discovered that Christianity is more receptive to contraception than other religious groups or sects

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(Kehinde, 2013). Nonetheless, little research has been conducted in the study area on the influence of religion on access to SRHS more especially as it relates to PWDs.

Voluntary family planning is one of the great public health advances of the past century. Enabling women to make informed decisions about whether and when to have children reduces unintended pregnancies as well as maternal and newborn deaths. It also increases educational and economic opportunities for women and leads to healthier families and communities. Even though Family planning is a smart, sensible, and vital component of global health and development, the reports show that more than 220 million women in developing countries who do not want to get pregnant lack access to contraceptives and voluntary family planning information and services. Less than 20 percent of women in Sub-Saharan Africa and barely one-third of women in South Asia use modern contraceptives. In 2012, an estimated 80 million women in developing countries had an unintended pregnancy; of those women, at least one in four resorted to an unsafe abortion (Mohapatra, 2016).

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Significant challenges stand in the way of making contraceptives more widely available and accessible, including insufficient donor and developing country funding, lack of appropriate products that meet users’ needs, weak distribution systems, lack of reliable monitoring and data collection mechanisms, and cultural and knowledge barriers (Bill Gates, 2015).

Perhaps the thorniest issue in relation to sexual reproductive health in recent years has been the debate over choice to abortion. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either

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by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (Iqbal,2014). Historical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers. According to The American College of Obstetricians and Gynecologists (November 2014),approximately 21 million women around the world obtain unsafe, illegal abortions each year, and complications from these unsafe procedures account for approximately 13% of all maternal deaths, nearly 50,000 annually.

Interestingly, studies reveal that unsafe abortion rate declined in all regions, except in Africa where it remained constant from 1990 to 2008 at a rate of 28 per 1000 women in reproductive age (15-44) years. Iqbal (2014) observe that the number of deaths due to unsafe abortion has declined from 69, 000 in 1990 to 47 000 in 2008; corresponding to an annual decline in unsafe abortion-related mortality ratio of 1% in Africa, compared to 4% in Asia and over 6% in Latin America. The case-fatality rate of unsafe abortion has also declined globally at a rate of nearly 3% annually, but remains many times higher than for safe abortion in developed countries. Nearly all unsafe abortions and related mortality occur in developing countries with sub-Saharan Africa accounting for 61% of all deaths due to unsafe abortion. The case fatality rate for Africa was 520 per 100 000 unsafe abortions in 2008(Iqbal, 2014).

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In discussing a major concern facing women and especially vulnerable women, Mahler (2007) raised the issue of unsafe abortion as a public health concern:

> *"Unsafe abortion continues to be a major public health problem in many countries. A woman dies every eighth minute somewhere in a developing country due to complications arising from unsafe abortion. She was likely to have had little or no money to procure safe services, was young - perhaps in her teens - living in rural areas and had little social support to deal with her unplanned pregnancy. She might have been raped or she might have experienced an accidental pregnancy due to the failure of the contraceptive method she was using or the incorrect or inconsistent way she used it. She probably first attempted to self-induce the termination and after that failed, she turned to an unskilled, but relatively inexpensive, provider. This is a real life story of so many women in developing countries in spite of the major advancements in technologies and in public health" (Mahler, 2007).*

The American College of Obstetricians and Gynecologists (2014) observes that many factors influence or may even necessitate a woman's decision to have an abortion. These include, but are not limited to, contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to teratogenic medications. Additionally, pregnancy complications, such as placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and cardiac or renal conditions, may be so severe that an abortion is the only measure to preserve a woman's health or save her life. The American College of Obstetricians and Gynecologists (2014) therefore asserts that induced abortion, safe or unsafe, legal or illegal, is a universal phenomenon and has existed throughout recorded history. When faced with an unintended pregnancy, women seek abortion and self-induce it or find providers, irrespective of the law. Yet, abortion continues to be the most emotive and contentious issue in reproductive health.

Despite the fact that it is largely frowned upon, the records suggest that each year 44 million abortions take place worldwide, nearly half of them safely and the rest unsafely. Unsafe abortions present a critical public health and human rights challenge of the present time. Deaths and disability due to unsafe abortion continue to occur against the backdrop of major advances in the medical profession, especially in terms of the availability of safe and effective technologies and skills for induced abortion (Iqbal, 2014).

A host of barriers and challenges result in unintended pregnancies and restrict access to safe abortion. Iqbal (2014) argue that even though medical technologies for safe abortion are no longer a problem, the availability of and access to these technologies remains a formidable challenge. Countries that are in transition from more to less restrictive abortion laws have to build the infrastructure and skills. However other countries that liberalized the law in the last 10-15 years are still struggling to provide much needed services, including change in attitude of service providers. There is therefore the need in many countries to ensure universal access with adequately trained providers both in provision of safe abortion procedures, and also in counseling, together with necessary equipment and infrastructure.

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Iqbal (2014) further note that legal provisions governing access to safe abortion, availability and quality of official abortion services, fees involved in the procurement of a safe abortion, the attitude of health staff and approach to clients can all be major barriers. Lack of awareness of what the law actually permits among the public, women, legal and health staff alike persists. Access to abortion is also commonly restricted, not only by the law, but also by other barriers. Stigma against abortion is a fundamental barrier to accessing abortion services. Social and cultural impediments also contribute to delays in seeking abortion to a time beyond the limit set by the lawand thus leaving no option for women other than having an unwanted birth or a clandestine risky abortion (Iqbal, 2014).The American College of Obstetricians and Gynecologists (2014) also noted that stigma, harassment, and violence discourage abortion access and provision. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless. The stigma of obtaining an abortion, as well as for providing an abortion, may lead to secrecy, marginalization of abortion from routine medical care, delays in care, and increased morbidity from the procedure.

Guttamacher (2015) buttressed that adolescents who want to end their pregnancy typically take longer than adult women to realize they are pregnant, and these adolescents consequently have abortions later in gestation. Adolescent women are also more likely than older women to seek abortion services from untrained providers or self-induce, and they typically know less about their rights concerning abortion and postabortion care. Adolescents cite cost, a desire to keep the abortion secret and difficulty locating a safe provider as their main reasons for seeking unsafe or self-induced abortions. Studies on adolescents with disabilities are quite limited especially as it relates to the study area.

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Adolescents suffer a number of health consequences from unintended pregnancies. For example, they may be at a higher risk of high blood pressure, anaemia, excessive bleeding, obstructed labour, premature delivery, or death. In addition, children born to adolescent mothers have higher incidence of low birth weight (associated with neurological problems or retardation), premature birth, stillbirth, and neonatal mortality. Africa's adolescent pregnancy rates are the highest in the world: 12% of African women aged 15−19 give birth each year, compared with 6% globally and 3% in developed countries (WHO, USAID, 2008). Adolescents with disabilities could be more susceptible to the consequences of unintended pregnancies.

Political and policy barriers also continue to hinder legal reforms to permit abortion on request and to make services accessible where countries have reformed the laws. No other issue in reproductive health divides politicians and policy makers as abortion. More recently, the organized opposition to provision of safe abortion and efforts to make its access more restrictive are presenting formidable challenges. Together, these barriers and challenges deprive women from accessing safe abortion. This tends to expose women to unwanted births or to unsafe abortion and its devastating consequences of death and disability (Iqbal, 2014).

Iqbal (2014) also noted that unsafe abortion-related deaths and disability are however difficult to measure because of underreporting or misclassification. Given that these deaths or complications occur following a clandestine or illegal procedure, stigma and fear of punishment deter women and their families from reporting the procedure. Worldwide, unsafe abortion mortality is the third major cause of maternal death after haemorrhage and sepsis in childbirth. Unsafe abortion-related deaths were estimated at 47

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000 in 2008, down from 69 000 in 1990 as maternal deaths reduced to 358 000 in 2008 from a high of 546 000 in 1990. Deaths due to unsafe abortion are mainly caused by severe infections or bleeding prompted by the unsafe abortion procedure, or due to organ damage. Complications of unsafe abortion include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs. Each year, one in four women or an estimated five million women with unsafe abortion are likely to develop temporary or life-long disability requiring medical care (Iqbal, 2014).

Iqbal (2014) reports that pronounced differences are found by economic status with poor women much more likely to have an abortion performed by unskilled providers than well-off women. In discussing illegal abortion and its effect on people, we may have to consider that many women with disabilities who are generally poor and more vulnerable in communities are most likely to be the hardest–hit. Data on the issue are difficult to come by in Ghana and especially in communities where Christianity, Islam and traditional African religions especially in the northern part of Ghana predominates. No data had been gathered on the magnitude of the challenge to date. It is clear that in countries where abortion is highly restricted, women who are better-off can obtain an induced abortion from a medically trained provider (doctor or nurse) or can travel to a country with liberal laws. Iqbal (2014) further notes that when abortion is legally restricted, its provision by medically trained providers becomes more expensive making it out of reach for the poor women.

As noted by Iqbal (2014), removing legal restrictions on abortion is an essential, though insufficient action to improve access to safe abortion. In Ghana for example, discrepancies between the wording of the law (*de jure*) and its application (*de facto*) are

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common, and practice therefore can help or hinder access to and provision of safe and legal abortion. The knowledge and interpretation of abortion laws by health care staff, knowledge and general understanding of the law in the community at large and by women and their families in particular, significantly affect what women with an unintended pregnancy do (Iqbal, 2014). The available data generally have the challenge of lumping together different segments of the population as a unit for analysis. In doing that, such analysis glosses over the peculiarities of especially vulnerable populations including people with disabilities and their concerns in the matter.

It is in this respect that the yawning gap between the Law and lived experiences of women with disabilities becomes something worth exploring. The extent to which women with disabilities confronted with unintended pregnancies are affected by the issue of legal restrictions and its consequences on access to abortion services remains un-established in the study area of Garu-Tempane District. This study therefore seeks to contribute towards filling in this gap in our knowledge.

Another related issue in sexual reproductive health generally and in the case of people with disabilities has to do with antenatal care. Antenatal care may be broadly defined as encompassing pregnancy-related services provided between conception and the onset of labour with the aim of improving pregnancy outcome and/or the health of the mother or child. This care involves a series of assessments and appropriate treatments covering three components: monitoring of the health status of the woman and the fetus; provision of medical and psychosocial interventions and support; health promotion (Hollowell et al., 2009).The number of different interventions in antenatal care is large. These interventions may be provided in approximately 12-16 antenatal care visits during a

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pregnancy. The purpose of antenatal care is to prevent or identify and treat conditions that may threaten the health of the fetus/newborn and/or the mother, and to help a woman approach pregnancy and birth as positive experiences. To a large extent antenatal care can contribute greatly to this purpose and can in particular help provide a good start for the newborn child (WHO, 2003).

Women report many barriers to accessing prenatal care. Some of these include barriers that can be classified into societal, maternal, and structural dimensions. Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing the pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long waiting time, the location and hours of the clinic, language and attitude of the clinic staff and provider, the cost of services, and a lack of child-friendly facilities(Philippi, 2009).Some studies also identify poverty and low income levels as a barrier to access to ANC services in Uganda(Centenary,2010). Mustafa et al., (2015) pointed out that even though maternal care services are free in Sudan, additional cost of care-seeking related to transportation to facilities, supplies and the opportunity costs of travel and waiting time have made services less affordable to the poor and that the poor are resorting to unsafe practices as alternatives. Again, the peculiar barriers confronting women with disabilities whilst seeking health care or antenatal care have not been examined within the context of the Garu-Tempane District. Lumping together all categories of women seeking health or antenatal care for analysis does not elucidate the issues and challenges that this vulnerable group faces.

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Compounding the issue further is the fact that even though research studies reveal women and girls as the largest group in the global disability population, historically, this have been subjected to multiple types of discrimination (Tilley, 1998). In comparison to men with disability, women with disability are less likely to marry, have a higher incidence of divorce, earn less money, and are viewed more negatively by themselves and others (Tilley, 1998). They are thus considered by many to be among one of the most disadvantaged groups in modern society (Thierry, 1998).

According to Philippi (2009), knowledge of women's views on access to health services can help in development of policies to decrease barriers. Structural barriers could be reduced through changes in clinic policy and prenatal care format, and the creation of child-friendly waiting and examination rooms. Maternal and societal barriers can be addressed through community education (Philippi, 2009). Knowledge of the views of women with disabilities on access to antenatal care services and other sexual and reproductive health services and how such findings could have an influence on policy formulation and programmes to reduce barriers to access have not been explored in the study area.

The findings of Tilley (1998) point out that the challenges faced by women with disabilities when accessing health care are located in prejudicial social attitudes and discriminatory and exclusionary practices of individuals, organisations and institutions. It was noted in particular that ‘The attitudes of medical professionals towards disabled women as child bearers have often been based on myth rather than fact’ (Kallianes and Rubenfeld, 1997: pp. 208). These women may experience multiple layers of discrimination, exclusion and inequalities in access to, and use of, mainstream healthcare

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services (Combat Poverty Agency, 1995). All women experience challenges when accessing health care, but for women with disabilities the challenges are often disproportionate and inequitable (Lawthers et al., 2003). Health inequities are said to be those differences that are unnecessary, avoidable, unfair and unjust (Whitehead, 1992). Such inequities evolve from a complexity of factors including the segregation of women with disabilities, attitudinal barriers, physical barriers and the unmet needs for advocacy (Pillinger, 2004). No single challenge can be considered as compromising a women's access to health care, rather the challenges are an accumulation of several factors (Scheer et al., 2003). These challenges prevent women from accessing health care when required and only serve to isolate and alienate women with disabilities (Grabois et al., 1999) and lead them feeling as though they have failed as wives and mothers (Mitton et al., 2007). While these challenges may be relatively insignificant for women without a disability, for women with disabilities who need more interaction with, and have an increased need for, appropriate and accessible health care services, the challenges are very significant (Parish and Huh, 2006) and equate to an additional disadvantage in women's health and wellbeing (Iezzoni, 2003).

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Although interventions targeting female education may not have a short-term effect on enhancing service use, education should still be considered as a key intervention to promote the use of ANC services, not only because it will increase women's awareness, but it will also lead to increased empowerment of women and may improve their access to financial resources throughout their adulthood (Mustafa et al., 2015).

Women with some physical disabilities have higher incidence of complications during pregnancy and birth (Cross et al., 1992; Nunn, 1996; Baker et al., 1997; Nosek et.al., 2001; Gavin et al., 2006), thus they are categorised as 'high-risk' and their options for different provisions of care are limited.Some women with disabilities have found maternity care to be disjointed, reactive and delivered in an untimely manner (Albrecht, 2001) and others did not receive gynaecological screening services when necessary (Coyle and Santiago, 2002). Many expressed concerns about genetic inheritance of disability, while others struggled with the decision to forego essential medication for their medical condition to ensure a healthy baby (Baker et al., 1997; Carty, 1998). For women post spinal cord injury, sexual desire remains relatively unchanged when compared to pre-injury desire (Demasio and Magiples, 1999), and becoming pregnant after spinal cord injury is an achievable objective and should not be discouraged (Ehrenberg et al., 2003).

On the other hand, women with intellectual disability are often considered either asexual or hypersexual, with little or no ability to control their sexual expression, yet they have the same sexual needs and desires as people without intellectual disabilities (Aunos and Feldman, 2002; Keenan, 2006b). However, through the ages, women with intellectual disabilities were perceived as 'the most serious threat to society' (Trent, 1994:pp. 179), because they were viewed as abnormally fertile women who gave birth to defective children and spread sexually transmitted diseases (Jones, 1986; Perkins et al, 2002), therefore making them subjects 'to be dealt with' (Mental Deficiency Act, 1913 cited in Walmsley, 2000:pp. 65). They were often separated by sex or sterilised to prevent procreation (Stainton, 1992; Trent, 1994; Cocks et al., 1996; Walmsley, 2000; Black, 2003; Broberg and Roll-Hansen, 2005; McClimens, 2005; Keenan, 2006a).

Walmsley (2000) for example identified evidence in Bedfordshire 1916-1918 to indicate that women with intellectual disability were more likely to be institutionalised and their

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sexual conduct was a major factor in this decision. Perkins et al. (2002) suggest that the extended families of mothers with an intellectual disability are often the subject of discrimination, with the disability of their relative perceived as an individual pathology to be dealt with by medicalising and hospitalising them (Oliver, 1990; McClimens, 2005). Such women were also viewed as a social problem and the focus of rehabilitation (Simmons, 1978; Trent, 1994; McClimens, 2005; Keenan, 2006a).

Driving independently may not be an option for some women with a physical (or sensory) impairment so they are reliant on public transport, taxis or other individuals when travelling to and from health care facilities (Anderson and Kitchin, 2000; Lawthers et al, 2003; Prilleltensky, 2003; Scheer et al., 2003). Depending on the woman's geographic location and the availability of suitably adapted public transport, access to health care facilities and participation in other community activities may be severely curtailed. Inadequate transport to and from the health care facilities can pose significant challenges for women trying to get to appointments and to access reproductive care. Even when public transport is available, Meltzer et al. (2007) report how, in the United States, it is expensive, undependable and inadequately equipped to accommodate or secure women with a wheelchair (Smeltzer et al., 2007).

For some women, physical accessibility to the building is often the first and most obvious challenge encountered (HCHC, 2003; Thierry, 2006) and can be one of the most challenging aspects to obtaining care (Schopp et al., 2002).Evidence suggests that a substantial proportion of health care facilities and physician's offices are inaccessible to women with a physical or sensory disability (Campion, 1997; Welner, 1997; Grabois et al., 1999; DeJong et al., 2002; Smeltzer et al., 2007). It is estimated that 2 out of 5

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women with disabilities experience difficulty getting into and around the built environment of physicians' offices (Goodman, 1994).

However, health professionals are often unaware of the problems that inaccessible offices and clinics present (Smeltzer et al., 2007). Physical challenges which impede access convey the impression to women that they are unwanted, unwelcome and are a burden on health care providers (Kaplan, 2006).

The information needs of women with disabilities are varied and dependent on the type of disability or impairment experienced (McKay-Moffat, 2007). Women with disabilities, however, do experience difficulties in receiving quality health information (Nosek, 1992; Harris and Bamford, 2001; CHAI, 2008) and Campion (1997) and the Royal College of Nursing (RCN) (2002) found serious deficits in the provision of information in relation to pregnancy, childbirth and disability in the U.K.

The needs of expectant women with physical disabilities vary considerably more than for women without disabilities and contemporary models of antenatal education have been described as inappropriate (Conine et al., 1986; Blackford et al., 2000). Evidence suggests that the needs of women with disabilities are not being met when attending antenatal classes (Conine et al., 1986; Blackford et al., 2000; CHAI, 2008).

Some health professionals communicate with women with disabilities in a patronising (D’Eath et al, 2005) or authoritarian (Westbrook and Chinnery, 1995) manner. Campion (1997) reports that the language used by many health professionals reflects their prejudicial attitudes and ignorance and may leave women feeling fearful, uncomfortable and degraded. Even the physical positioning of health professionals in clinic areas reduces good communication, for instance, due to lack of eye to eye contact between a

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wheelchair user and those standing near them (McKay-Moffat, 2007). Thus inappropriate attitudes, behaviours and a lack of awareness (Nosek, 1992; HCHC, 2003; RCN, 2007) are the most significant subtle challenges encountered by women with disabilities when accessing health care during pregnancy, childbirth and early motherhood and are the most difficult to address and overcome (Schopp et al., 2002). Women with a disability will have very diverse backgrounds and different experiences and the disability will impact differently on the lives of each individual. When health professionals are unable to recognise and embrace this diversity it has a profound impact on the development of attitudes and whether or not women access the health care services (Kallianes and Rubenfeld, 1997; Shakespeare, 2000).

The myths and misconceptions surrounding women with disabilities have resulted in the construction of negative prejudicial attitudes towards them, and hostility, sympathy and pity are common associated emotions (DeLoach, 1994). These emotions and prejudicial attitudes heighten women's sense of vulnerability, insecurity, isolation and marginalisation and increase the pressure experienced by women as they embark on, and attempt to negotiate, the many challenges of pregnancy (McGuinness, 2006). One prominent myth is that women with disabilities are asexual (NWCI, 2006), uninterested in sex or are unable to partake in sexual activity. This assumption is 'pejorative' (Kaplan, 2006:pp. 450) and may result in health care providers denying access to appropriate services and care. The assumption is also untrue, as women with physical disabilities are sexual beings who engage in sexual activity. They, too, experience feelings of desire and love, seek sexual gratification and desire motherhood (Anderson and Kitchin, 2000). Vansteenwegen et al. (2003), however, note how some women with a physical disability

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tend to reject their sexuality, around which there is a great deal of negativity, prejudice and misunderstanding (Nisha, 2005).

Lee and Oh (2005) highlighted a range of barriers experienced by married women with a physical disability with regard to obtaining sexual and reproductive health care information. Barriers included lack of knowledge among health care professionals and the absence of medical facilities for people with disabilities. Becoming a mother is an aspiration of many women with a physical disability, which, according to McKeever et al. (2003) represents the ‘capturing of a gender or recapturing of a lost gender’ (McKeever et al., 2003:pg. 671) and provides women with a sense of normality. It is an avenue to societal acceptance, as becoming a parent shifts the focus from the disability to parenting and provides women with a platform that emphasises their independence and competency (Grue and Tafjord-Laerum, 2002). Pregnancy and parenthood is thus perceived as a triumph over their disability (Goodman, 1994). However, many women with physical disabilities planning to become pregnant are exposed to prejudicial attitudes of others and experience tremendous pressure not to do so (Baker et al., 1997; HCHC, 2003; Prilleltensky, 2003; McFarlene, 2004; Thierry, 2006). These attitudes are quite often founded upon, and impregnated with, a eugenic philosophy and ethos and are described as dehumanising (Grabois, 2001). Consequently, women may forgo pregnancy and parenting because they fear that their disability will be inherited by their child or that the child may be psychologically deprived or burdened by the fact that one or both parents have a disability (Carty, 1998). Health professionals sometimes label women with disabilities as having an unwanted, unplanned pregnancy and desiring a termination,

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which exemplifies their assumption that women with disabilities are incapable of becoming a parent (Welner, 1997; Carty, 1998; Prilleltensky, 2003).

Having a physical disability and needing help are in contrast to the normal representation of mothering (McKeever et al., 2003) and health professionals may find it difficult to comprehend these women's ability to mother, nurture and care for their baby (McFarlene, 2004). Women with physical disabilities describe how they perceive themselves to be constantly judged and scrutinised by health professionals and are fearful that they would be considered a failure (Prilleltensky, 2003; McFarlene, 2004). Many are afraid to ask for assistance as they fear that such a request would be interpreted as them being incapable and unable to cope with the functions of their new role (Thomas and Curtis, 1997; McKeever et al., 2003; McFarlene, 2004). Health professionals often interfere and provide unhelpful advice and care which only reinforces the woman's sense of difference and signals their inadequacy (Thomas, 1997). Frequently, alternative solutions offered or proposed by women that could help them master the skills associated with practical baby cares are considered inappropriate by health professionals (Thomas, 1997) and they fail to appreciate women's expertise in mastering and adapting to their disability.

Prejudicial attitudes combined with insensitive and derogatory comments only serve to diminish a woman's self-esteem and self-efficacy and cause her to doubt her own ability to be an effective mother (Welner, 1997). This erodes women's sense of autonomy and empowerment and they become passive and compliant in their interaction with health professionals (Prilleltensky, 2003), describing how they feel depersonalised and a burden on the health services (Smeltzer et al., 2007).Kent (2002) observes that women with visual impairment may be faced with a constant battle to maintain a sense of dignity and

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respect when accessing health care. One in 10 women with a vision impairment experiences, for example, some degree of difficulty in accessing and negotiating the internal environment of health care facilities (Nzegwu, 2004). Details of appointments and correspondences are usually in written format, which is inappropriate for women with a visual impairment. When availing of these services, the majority of women with a visual impairment will require orientation to the health care setting (Pierce, 2003). This should include assistance in completing registration forms, locating a seat in the waiting area, and moving or transferring to and locating the examination rooms, but very few women receive this assistance (McFarlene, 2004; Nzegwu, 2004). To overcome these challenges, many women rely on relatives and friends to accompany them to appointments (Nzegwu, 2004). Lack of orientation to the birthing and postnatal environment reduces the woman's familiarity with the area and increases her dependence on health professionals, which impinges on her ability to care confidently for her baby without constant assistance (McFarlene, 2004). These challenges are further compounded by health professionals' lack of awareness of how actions or lack of them may or may not impact on the individual's perception of self (Nzegwu, 2004).

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Getting accessible information is a perpetual challenge experienced by women with a visual impairment (CHAI, 2008). The challenges bother on the individual's level of knowledge about pregnancy, childbirth and motherhood, and their knowledge of Braille (Smeltzer, 2007). Health professionals' attitudes and a lack of awareness of individual needs compound these challenges even further (Beverley et al., 2004). The vast majority of vision-impaired women do not receive any health information advice or leaflets in an appropriate or preferred format, for example, large print, pictorial, video and/or audio format or Braille (Nzegwu, 2004), so trial-and-error learning is a common experience of many vision-impaired parents (Conley-Jung and Olkin, 2001).

Deborah Kent, in her paper enumerates the challenges she encountered as a blind woman during pregnancy, birthing, and early motherhood (Kent, 2002). Health professionals' and societal attitudes featured prominently. She discusses how motherhood afforded her an 'exhilarating sense of defiance' (Kent, 2002:pp. 81) against society's stereotypical misconceptions. She discusses society's negative attitudes about blind women and motherhood, and the way these attitudes become real and tangible obstacles in a blind woman's life. She recalls how health professionals after the birth of her daughter, tried to discourage the practice of rooming-in, citing her incapacity to see the baby's cot and baby as the reason to separate mother and baby at such a critical time. Kent recalled painful encounters in which health professionals questioned and challenged the competence of a blind woman to mother, nurture and care for her baby. Comments were often patronising and derogatory and she felt that health professionals and others were judging her parenting skills. Kent acknowledges how many a new mother lives with 'performance pressure' (Kent, 2002:pp. 85), but a visual impairment only serves to heighten the pressure as mothers constantly struggle to prove that they can successfully fulfil the requirements of their mothering role (Conley-Jung and Olkin, 2001; Kent, 2002).

According to Steinberg (2006), women who are deaf engage with health care services in two ways, as 'individuals and as a member of a minority group' (Steinberg, 2006:pp. 2530) and are likely to be subjected to layers of different and compounding inequalities. The experiences of women who are deaf when accessing health care are under-researched

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and services are under-developed, although some studies (Harris and Bamford, 2001; Steinberg et al., 2002; Ubido et al, 2002; Valios, 2004; Tingle and Dunmore, 2005; Steinberg, 2006) have highlighted the challenges encountered by women when accessing health care. Also, Mprah (2013) states that the hearing impaired in Ghana encounter difficulties when accessing services as services do not reflect their felt needs.

When interacting and interfacing with health professionals the majority of women with hearing impairment do not feel respected or supported (Steinberg, 2006). Similar to women with a physical disability, their deafness becomes their defining characteristic to the detriment of the perception that they are competent individuals. Health professionals tend to be paternalistic and patronising (Steinberg, 2006) and health professionals' assumptions about the woman's deafness significantly impacts on the establishment of a productive relationship (Iezzoni et al., 2004). Health professionals fail to recognise and appreciate the totality of deaf women's lives. Disrespecting the woman's intelligence, motivation and her wishes to participate in her care is a common experience when women encounter health professionals (Iezzoni et al., 2004). The lack of knowledge of health professionals about the auxiliary aids that could assist women with hearing impairment in their parenting tasks is also a huge source of frustration for many deaf women (Harris and Bamford, 2001). Many women report being offered additional prenatal anomaly screening (Stern et al., 2002; Piotrowski and Snell, 2007) and feeling pressurised to consent to such screening, or feeling guilty or selfish if they gave birth to a disabled child.

According to the Royal College of Psychiatrists, women who experience perinatal mental health difficulties, rapid access to appropriate specialist services and treatment is

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recommended to lessen women's maternal distress and the possible negative impact on the baby (Royal College of Psychiatrists, 2002). Perinatal mental health services should be seamless; embracing a number of specialist areas, and with interdisciplinary working between midwifery, obstetrics, mental health professionals and general health professionals. However, services to women who experience perinatal mental health difficulties are often non-existent, disconnected, fragmented, difficult to access or inadequate in meeting the specialist needs of mothers (Miller and Finnerty, 1996), and links between maternity and mental health services are weak (Currid, 2004). Consequently, women experience suboptimal perinatal care, with their mental health issues being considered separately from their pregnancy (Miller and Finnerty, 1996). Currid (2004) is of the view that maternity staff focus on biological aspects of pre and post natal care, view pregnancy and childbirth as their domain, and fail to see that maternity care embraces a number of specialist areas.

Stehlik (2001) traces the history of the development of negative attitudes towards the sexual and reproductive capability of women with intellectual disabilities. These negative attitudes, she argues, continue today, with prevention of conception as the ultimate aim, through the employment of involuntary sterilisation and non-consensual contraception. Priestly (2000) argues that the infantilisation of women with intellectual disability allowed their reproductive health to be ignored, with no impetus to carry out breast examinations and cervical smear testing or to maintain menstrual care. The existence of these disparities has only in recent years come to light and is now becoming a focus of care (Ditchfield and Burns, 2004; Rodgers and Lipscombe, 2005; Rodgers et al., 2006).

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Studies have found frontline caring staff and parents to have conservative and protective perspectives regarding the sexuality of women with intellectual disability (Cuskelly and Bride, 2004; Drummond, 2006). Such women are often considered unable to make rational informed choices about pregnancy and motherhood, and are at greater risk to coercive sterilisation or forced contraception (Tilley, 1998; NDA, 2007).

Review of the literature on sexual and reproductive health of women with disabilities generally reveals a gap in research pertaining to their pregnancy or maternity-related healthcare needs especially in Ghana generally. In order to fill this gap, the current study aims at investigating issues and challenges that women with disabilities face in the quest for sexual and reproductive health care services in the context of socio-cultural beliefs and attitudes in Garu-Tempane District.

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CHAPTER THREE

METHODOLOGY

3.0Introduction

This chapter gives information about the study area, research design, population of study, sampling procedures, methods of data collection, data analysis procedure, ethical considerations and the limitations of the study.

3.1 Study area

The study was conducted in the Garu-Tempane District of the Upper East Region of Northern Ghana. It is essentially a rural area with an estimated population of 130,003(PHC, 2010). It shares boundaries with the Bawku Muncipal Area and parts of Pusiga District to the North, the Bunkpurugu-Yonyoo District to the south, the republic of Togo to the East and the Bawku West District to the west. It covers an area of 1,230 Km^2. It lies on approximately latitude 10^o 38^{l}N and11^{0}N and longitude 0^o 06^l E and 0^0 23^l E.

The vegetation of the area is typical of the savannah grassland with short scattered trees and with only a few areas of forest reserves. It is an agrarian settlement and over 70% of the area's population engaged in subsistent farming for livelihoods. Agriculture, the mainstay of the area is rain -fed and there is little to be done during the dry season when the rains cease. The main crops include millet, maize, sorghum, rice and vegetables. Livestock includes cattle, sheep, goats, local fowls among others.

It is a heterogeneous community comprising of Kusaasi, Bimoba and Bissa as the main ethnic groups. These ethnic groups are well integrated and share some common cultural values which define their identity and influences their ways of life. They are religious and

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though may belong to any one of the three main religions in the area namely: Christianity, Islam and the Traditional African religion, there is peaceful co-existence.

In all, a total of 56 health facilities both government and private exist in the district, providing health care services including sexual and reproductive health services to meet the health needs of the population. All these health facilities were covered by the study.

3.2 Research Design

The research was a cross-sectional study. A combination of both qualitative and quantitative data collection methods was deployed. These included: Health facility observation, interviews with PWDs exiting from SRH facilities, key informant interviews with service providers and the use of the mystery client approach to explore the attitudes of service providers and other service users. The researcher and the respondent agreed to sit in a private place to conduct the interviews.

Research questionnaires were administered, some variables were quantified and others explored in-depth, thus generating descriptions. In addition, 8 focus group discussions involving four disability types namely: the physically impaired, the hearing/speech impaired, the visually impaired and those with mental disabilities were conducted and these generated essentially qualitative data which were recorded and interpreted. Content analysis was used in analyzing qualitative results whilst descriptive statistics involving charts and tables were used for quantitative results.

3.3Study Population

These included people with disabilities within the reproductive cycle (15-49) and health workers in the study area.

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3.4 Study Unit

The study units were health facilities that rendered SRH services and male and female persons with disabilities within the reproductive age group 15-49 in the study area.

3.5 Sampling Techniques and Procedures

The researcher purposively obtained the list of health facilities providing sexual and reproductive health services from the Garu-Tempane District Health Directorate. In all, there were 56 facilities made up of 6 health centres, 44 CHPS compounds and 6 clinics. In order to enhance the validity of research results, the entire population of 56 facilities was chosen for the study. Besides, purposive sampling techniques were employed to identify members of specific disability groups existing in the study area. These included the Ghana Society of the Physically Disabled (GSPD) with a total membership of 24, the Ghana National Association of the Deaf (GNAD) which had a total of 30 members, the Ghana Blind Union (GBU) with a total membership of 25 and mental health self-help (MH-SHG) group made up of 26 members. The Cochrane formula for sample size determination was used to calculate the sample sizes for each disability group;

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

(Source: Cochrane, 1997)

Where n = sample size; n0 = required return sample size according to Cochrane formula (0.05 margin of error) (t) 2*(p) (q)/(d)2=384; N= Population size.

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For GSPD, n=384/ 1+ (384-1)/24 = 22. The table below shows sample sizes calculated based on the formula for each disability group:

Table 3.1: Sample Size Determination for Disability Groups

Disability Group	Population(N)	Sample size (n)
GSPD	24	22
GBU	25	23
GNAD	30	27
MH- SHG	26	24
Total	105	96

Source: Secondary Data from Disability Groups

The researcher further employed stratified random sampling techniques to disaggregate the sample sizes by sex and age. For the age the variable, those that fell within the active reproductive category (15-49) were selected as participants of Focus Group Discussions. The use of stratified sampling techniques ensured that participants with the right age were selected since age was considered an important variable in the study because of its implications on sexual and reproductive health issues. Again, it ensured that both male and female PWDs were selected which made it possible for the research to explore the gender perspectives in the study.

Moreover, in order to enrich the data, 21 key informants who were mainly SRH service providers were chosen purposively for in-depth interviews on the topic. The purposive sampling techniques were used to select the SRH service providers based on their knowledge on the issue of study. Interviews were also held with 45 PWDs exiting from

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SRH facilities and these were selected using convenience/accidental sampling techniques and the choice of sample size was determined using the Cochrane formula stated above. As the research was not interested in all persons with disabilities but those that fell within the active reproductive age group, the researcher relied on secondary data from the CBR annual report for 2015 which depicted that there were a total of 51 PWDs within the active reproductive age group in the study area. The sample size was calculated: n= 384/ 1+ (384-1)/51=45. The use of the convenience /accidental sampling techniques to arrive at the sample was to enable the researcher explore the disability type that is more able to access sexual and reproductive health services generally. In all 15 respondents were selected from Garu Health Centre, 10 from Worinyanga Health Centre, 13 from Quality Medical Centre and 7 from Rabito clinic. These facilities were chosen for the study because they are referral points were people generally visit for health care services in the district.

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3.6 Health Facility Observation

All 56 SRH facilities in the study area were visited and an accessibility assessment conducted through the use of a checklist. This took the form of recording SRH facilities that had accessibility provisions and those without accessibility provisions. The researcher also made direct observation regarding the physical situation and the accessibility of SRHS to PWDs generally. Appendix I indicate the checklist used for the study.

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3.7 Focus Group Discussions

Focus Group Discussions were held with 4 disability groups, namely: the physical challenged, the hearing/speech impaired, the visually impaired and the mentally challenged. The participants for the FGD involving the physically challenged group were 22, that of the hearing/speech impaired were 30, the visually impaired group were also composed of 23 whilst that of the mentally challenged were 24. In order to have a sizeable number for effective focus group discussions, each group was subdivided into 2, making a total of 8 focus groups in all. This provided data on specific disability types and their peculiar challenges regarding access to SRH services. There were 3 research assistants (1 moderator, 1 camera man and 1 sign language interpreter) who supported the researcher during FGDs. The moderator facilitated the discussions using a focus group discussion guide, the sign language interpreter translated the discussions into sign language for the hearing/speech impaired and the camera man took video records whilst the researcher took down notes. Each discussion lasted for 1-2 hours. Appendix II is a Focus Group Discussion Guide used for the study.

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3.8Key Informant Interviews

Key informant interviews were held for 21 service providers who were selected purposively based on their knowledge on sexual and reproductive health issues and their experience in dealing with clients, including PWDs who seek their services. They were chosen from facilities that serve as referral points for SRH service delivery in the district. These included 5 midwives (2 from Garu Health Centre and 1 each from Worinyanga Health Centre, Quality Medical Centre and Rabito Clinic); 3 physician Assistants (1 each

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from Garu Health Centre, Worinyanga Health Centre and Quality Medical Centre); 5senior nursing officers (2 from Rabito Clinic and 1 each from Garu Health Centre, Worinyanga Health Centre and Quality Medical Centre), 1 District Health Director from the Garu-Tempane District Health Directorate, 1 Dispensary technician from Garu Health Centre and 6TBAs (1 each from 6 sub-districts namely Worikambo, Songo, Denugu, Worinyanga, Basyonde and Bugri). Find the interview guide that was used for key informant interviews in appendix III.

3.9 Client Exit Interviews

The research team administered questionnaire to 45 PWDs who were exiting from designated SRH facilities. These facilities included: Garu Health Centre, Worinyanga Health Centre, Quality Medical Centre and Rabito Clinic and they were chosen because they serve as referral points for SRH service delivery in the study area. Respondents were selected accidentally based on their arrival in SRH facilities for services. They included 23 physically challenged, 10 visually impaired, 4 mentally challenged and 8 hearing/speech impaired persons. For interviews with the hearing/speech impaired, the researcher made use of sign language interpreter to translate interview questions and the responses. The questionnaire used for interviews can be seen in appendix IV.

3.10 The Mystery Client Approach

The researcher made use of the mystery client approach to explore the attitudes of service providers and to observe the treatment they mete out to PWDs at service delivery points. In that regard, the researcher in a disguised costume visited designated SRH facilities to seek services and made direct observations. First, the researcher acted as a physically

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challenged person on a wheelchair seeking SRH services in 3 designated facilities. Secondly, the researcher acted as a visually impaired person and with the aid of guide, visited 4 SRH facilities for services. Again, the researcher acted as a hearing/speech impaired person and visited 5 SRH facilities. Also, at another time, the researcher acted as a person with mental disability and visited 3 facilities for services. This made it possible for the researcher to explore the attitudes of service providers and other service seekers towards the various disability types and PWDs generally. Some secrete audio recordings were made using a miniature audio recorder in a pocket. This method was employed to enhance the validity and reliability of the research findings and was deemed more appropriate because attitudinal issues are sensitive and respondents may not be honest enough to provide reliable responses on their own attitudes especially when such attitudes are negative.

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3.11 Data Analysis

Quantitative data were entered into computer software and analyzed using the statistical package for social scientists (SPSS). Results were presented and interpreted using tables, frequencies and charts. The Pearson Chi -square test was deployed to investigate the association between some variables and this was tested at 0.05 significant levels. Thus, with a confidence interval of 95%, the variables studied were considered statistically significant where the p values were less than 0.05.

Qualitative data were entered into a Microsoft Word computer program and analyzed manually following a content thematic approach. Data recorded with video and audio tape recorders were transcribed verbatim in a text format and read to identify themes and sub-themes for further analysis and interpretation.

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3.12 Ethical Considerations

The researcher obtained all the necessary clearance from the School of Medicine and Health Sciences of the University for Development Studies and the district authorities where the research was carried out. These included clearance from the Garu-Tempane District Health Directorate and permission from management of the various health facilities where the study was conducted.

Besides, the researcher sought the consent of respondents before interviews were conducted. No individual or group was induced, coerced or deceived to participate in the study. Respondents could participate or withdraw their participation anytime they wished. Respondents could also opt to answer some questions or not based on what they wanted.

Privacy was guaranteed by ensuring that respondents were secluded before questionnaires were administered. In-depth interviews with key informants were held in rooms where there was no interference whilst FGDs were held in confined environments. These ensured confidentiality and willingness to participate fully.

Moreover, the values and norms of the local people were studied well and respected to avoid any misconception.

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3.13 Limitation of the study

Resource constraints on the part of the researcher limited the ability of the research to cover more PWDs and service providers in order to discover their perspectives on the subject of study.

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CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents and analyses the findings of the study in relation to sexual and reproductive health challenges encountered by PWDs in accessing services such as family planning, antenatal care, abortion and contraception as well as HIV/AIDS services. The chapter presents findings drawn from both the quantitative and qualitative approaches use in collecting the data.

4.1 Sample and Response Rate

In all, a total of 56 SRH facilities were visited for the study, 45 PWDs exiting from designated service delivery centers were interviewed. In addition, 8 Focus Group Discussions involving four disability specific groupings: the Physically Challenged; the Visually Impaired; the Hearing/Speech Impaired and the Mentally Challenged were held. Key-informant interviews were held with 21 Service Providers to enrich the data gathered on the topic. Mystery-client approach was also deployed specifically to explore attitudes towards PWDs at designated service delivery points. The chapter uses tables and charts in presenting quantitative results. In this chapter, qualitative results are principally used to augment and explain findings drawn from the quantitative data presented. Findings are then interpreted and discussed in the context of the study’s objectives and research questions. In order to enhance easy analysis and interpretation of data, the findings have been grouped under themes and sub-themes presented in the ensuing sections of the chapter.

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4.2 Socio-demographic characteristics of respondents

The section focuses on the socio-demographic characteristics of respondents in terms of basic characteristics of the sampled population, that is, age, sex, education, economic status, level of education, marital status and religion as well as the extent to which these factors influence the accessibility of sexual and reproductive health services by PWDs. The section forms the basis of the background information by which most key demographic and health indices are analyzed throughout this report.

4.2.1 Age

Age is considered one very important variable in this study because of its implications for sexual and reproductive health issues generally. Findings show that the mean age of respondents was 41 years.Majority of respondents (86.5%) were aged between 15 and 44 years. The findings show that the sample is quite tilted to cover those within the reproductive age segment of the population. This is mainly because they were considered more relevant to the study in terms of their knowledge and experience on the issue.

4.2.2 Sex Distribution

Sex distribution of respondents is deemed important against which the knowledge, attitudes and behavior related to sexual health as measured by selected indicators could be pitched for analysis (Fig 4. 1).

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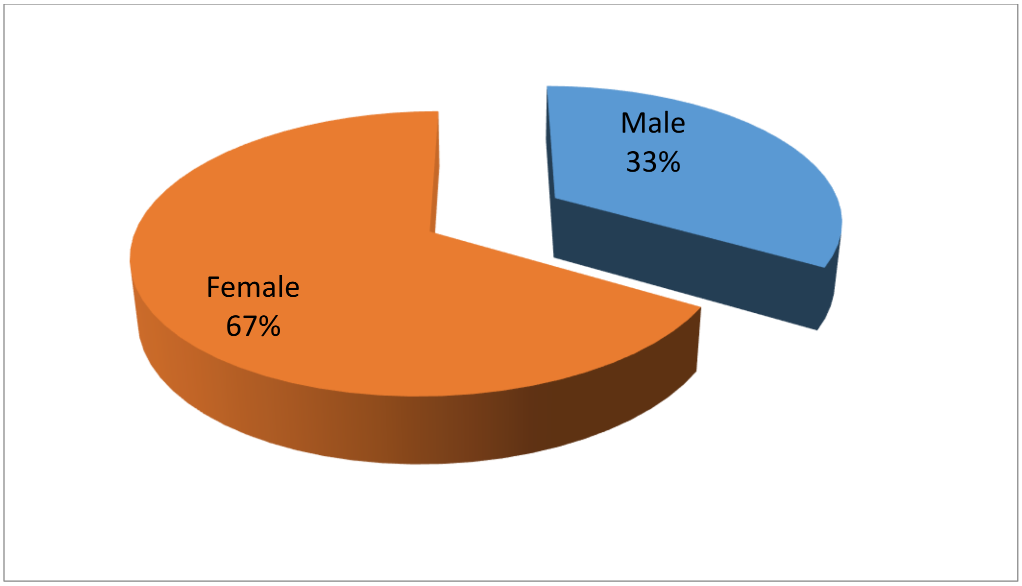

Figure 4.1: Sex Distribution

Source : Client Exit Interviews

Figure 4.1 shows that that majority of respondents (67%) were female as against slightly more than a third (33%) male. The situation could be explained in relation to the fact that as noted in Chapter 3, this study was health-facility based. Specific health facilities in the district were visited for 4 Weeks and all PWDs reporting for health services were taken for this study. This implies that more females visit health facilities or service outlets for SRHS than male.

4.2.3 Disability

For the purposes of this study, it was deemed important to segment PWDs by type of disability. It was thought that this would be useful in the analysis especially in relation to exploring the question as to whether some category of PWDs are generally more able than others to access health facilities. Figure 4.2 gives a summary of the findings in respect to the sub-groups of PWDs that were respondents in this study.

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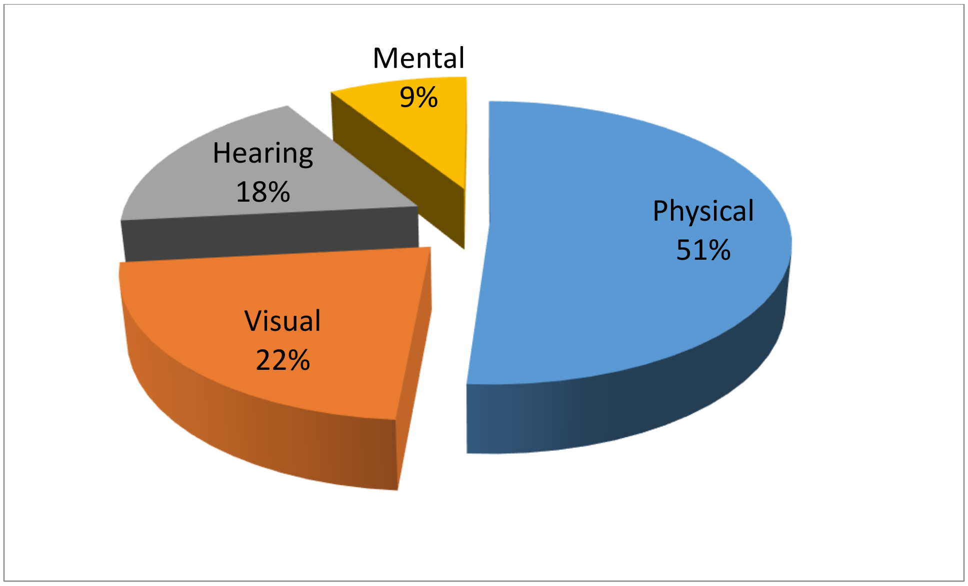

Figure 4.2 : Types of Disability

Source: Client Exit Interviews

Findings indicate that those with Physical Disabilities (51%) were the majority, followed by the Visually Impaired (22%), then the Hearing/Speech Impaired (18%) and the least being those with Mental Disability (9%). The findings confirm casual observations that even though in Ghana, PWDs generally find it difficult because of stereotypes to mingle with the public, among the general group of PWDs, People with Mental Disability are regarded as the most incapacitated and unable to function meaningfully within society. No doubt as shown by Figure 4.2, People with Mental Disability are the least reporting at the health care service point. It suggests that PWDs in this category shy away from the public because of the stereotypes they have to endure generally.

Further probe reveals that respondents feel that health facilities are not PWD-friendly. The findings point to the general impression for example that physical structures at health facilities do not easily respond to the peculiar needs of PWDs. Interviews suggest that at best, some of these facilities have pavements for wheelchairs. Even here, these were made ostensibly for physically able people who become incapacitated – emergency cases or response services providing basic life support and critical care for patients rushed to emergency units. No doubt, as shown in Figure 4.2, this facility may provide some advantage to PWDs in the category of Physical Disabilities (wheelchairs) to access public health service points independent of any direct assistance from anyone. The Visually Impaired and the Hearing/Speech Impaired on the other hand have no such support systems in place and need to rely on other people to access health facilities. Respondents said in most cases, isolation and segregation have perpetuated many of these stereotypes. Adult freedom and autonomy is compromised and PWDs feel controlled and cajoled by those who physically help them find their way. Indeed, confidentiality is compromised always. Thomas, a blind Teacher explains how he feels about the situation:

> *People, even far younger than you, take freedom to lord it over you always. You are nobody. People feel they must talk on your behalf even before the doctor. They believe they know what is wrong with you and can explain better. It is assumed always that we PWDs are neither able to take responsibility for our own needs nor stand accountable for our actions and choices… It is a difficult situation …* (Thomas, 32-year old male Teacher in BC JHS).

Apart from health facilities not having the appropriate physical architecture to be PWD-friendly, negative attitudes and stigma about people with disabilities abound with personnel of these facilities. Felicia (a respondent) shared her experience about her encounter with some nurses.

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> *We don't have any special place for PWDs in health institutions. If it is a queue, you are assumed to be able to queue like any other patient. When others complain about how slow the service is, PWDs are not expected to voice any opinion. The assumption is that PWD are "second-class citizens" not entitled to the same rights and privileges as a person without a disability. (Felicia 34-year old female, married with 3 children, a physically impaired person from Denugu)*

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4.2.4 Marital Status

Information on Marital Status is crucial for the interpretation of key demographic and health indicators. This is especially because marriage is a primary indication of regular exposure of women to the risk of pregnancy. Marriage therefore becomes important for the understanding of fertility. Thus data on marital status could help draw meaningful policies and programmes for intervention. Respondents were thus asked to indicate whether they were single, married, cohabiting, divorced, or widowed. Figure 4.3 presents the summary of the findings.

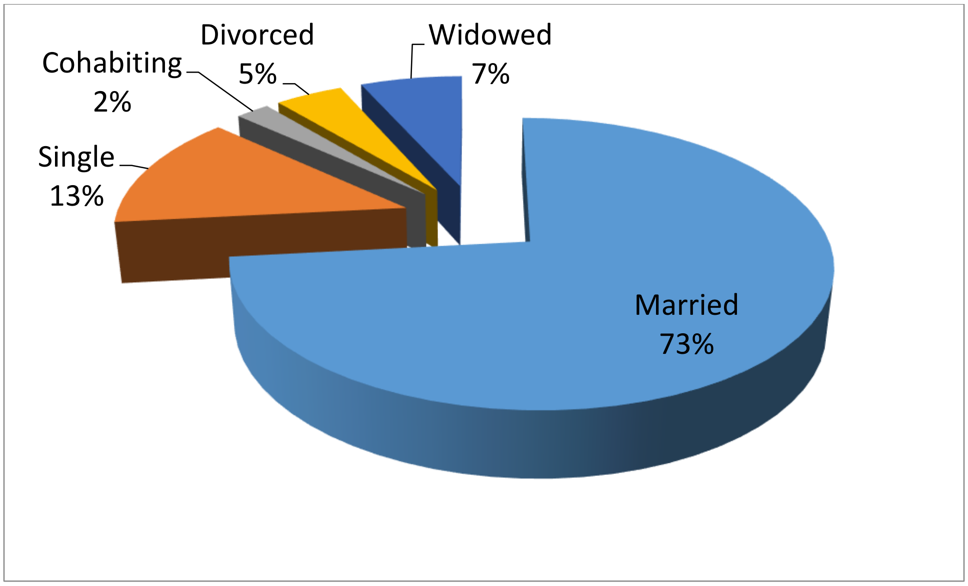

Figure 4.3: Marital Status of Respondents

Source: Client Exit Interviews

The data demonstrated that majority of respondents (73%) were married. Indeed this is not unexpected given the age group of respondents generally. It is interesting that only few (2%) of respondents said they cohabit and are not properly married at the time of the study. Given that marriage is also a proxy for integration into society, the findings suggest that PWDs are integrated into the society generally.

4.2.5 Level of Education

Education is known to provide people with the knowledge and skills that can lead to a better quality of life. Among other issues, reproductive health behaviours of women and men are said to be influenced heavily by the level of education a person has. The level of education of an individual may also influence their health seeking behavior. This study sought among other things therefore to establish educational level of respondents and to explore the link between the educational level of PWDs and access to SRHS. Figure 4.4 below gives a summary of the results:

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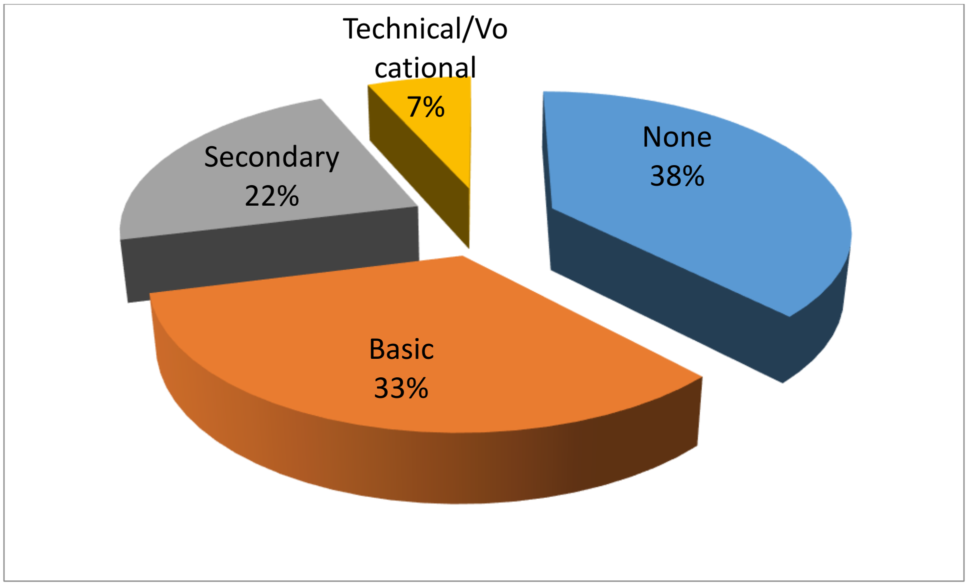

Figure 4.4: Level of Education of Respondents

Source: Client Exit Interviews

From Figure 4.4 above, over a third of respondents (38%) never attended school, 33% attended school up to basic level, whilst 22% went through Secondary and 7% were through Technical/Vocational training. In all therefore, majority of respondents (62%) had had at least basic formal education. Findings however suggest that the far majority of respondents (71%) have either never been to school (38%) or dropped out of school after basic education (33%).

4.2.6 Employment Status

Another important socio-demographic variable in this study relates to employment status of respondents. Literature has shown a relationship between employment status and income of individuals. Since income status influences individual's health seeking behaviour including SRHS, this study sought to establish the employment status of

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respondents, including the specific occupations that they were engaged in. The results are presented in Table 4.1 below:

Table 4.1: Occupational Distribution

Occupation	Frequency	Percent
Farming	12	26.7
Apprenticeship	1	2.2
Food vendor	1	2.2
Dress making	6	13.3
Trading	8	17.8
Hair dressing	2	4.4
Public servant	1	2.2
Unemployed	14	31.1
Total	45	100

Source: Client Exit Interviews

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The results indicate that slightly over a third of respondents (31%) were unemployed. This means that majority of respondents (69%) were employed. About 27% were engaged in subsistence farming; Traders (18%), and Dressmaking (13%). It is interesting that generally respondents (about 70%) were employed under private enterprises and only one person was a Public Servant. This may be explained in relation to poor level of education attained as shown in Figure 4.4.

4.2.7 Religion

Religion influences human behaviour, perception and attitudes. In other words, people’s religious persuasion defines their belief systems and determines their perception, orientation and lifestyles. The study sought to establish the religious affiliation of respondents and how sexual and reproductive health service accessibility could be influenced by religion. Figure 6 gives summary of the findings.

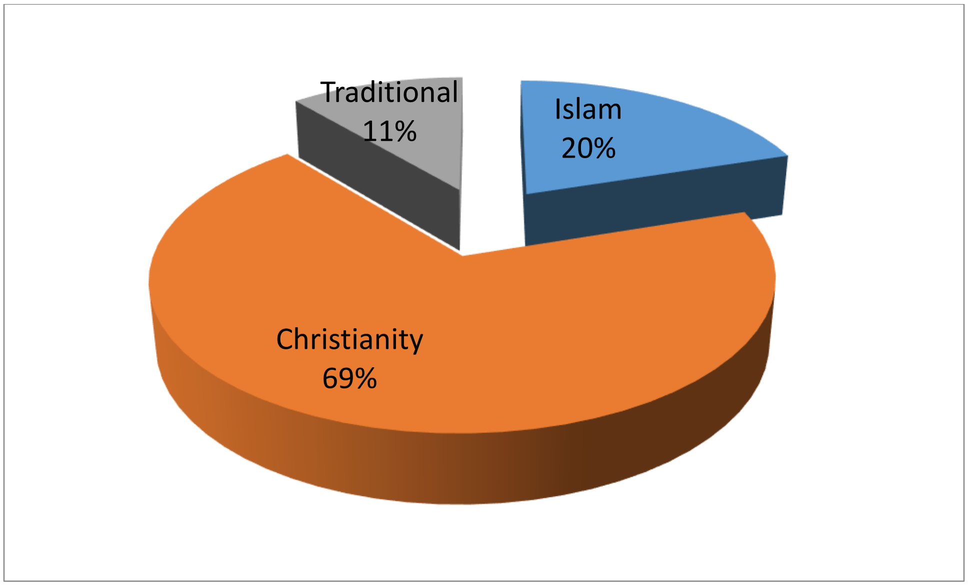

Figure 4.5 : Respondents' Religion

Source: Client Exit Interviews

From figure 4.5 above the study findings revealed that majority of the respondents were Christians comprising of 69%, followed by Muslims (20%) and the least being Traditional believers (11%). Given the backdrop of the fact that the study was health - facility based and the sample drawn from PWDs who reported to service delivery points or health facilities within the study period, the findings suggests that the religious affiliation of PWDs influences their utilization of SRHS.As depicted in figure 6, more PWDs who profess the Christian faith (69%) reported to service delivery points or

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facilities to utilize SRHS than those of the other religions like Islam (20%) and the African Traditional Religion (11%). Upon a further probe to establish the rationale behind the finding, Florence (A respondent) made this assertion:

> *Unlike Islam and the Traditional religion, Christianity does not encourage that we have multiple sex partners. It also encourages that we try to stick to our partners and satisfy them sexually so that they don't engage in infidelity. As a result, we resort to the use of contraceptives to enable us meet the sexual needs of our husbands and at the same time reduce the risk of unintended pregnancies.*
>
> *(Florence, 37 year physically challenged person, Garu -Natinga)*

4.3 Responses on Challenges Restricting Access to SRHS by Persons with Disabilities

Apart from the socio-demographic characteristics, respondents were asked to enumerate the challenges that restrict their ability to have access to SRHS in terms of HIV/AIDS, abortion, family planning/contraception and ANC services. The responses were as follows:

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Table 4. 2: Responses on Challenges Faced by PWDs in Accessing Sexual & Reproductive Health Services

HIV/AIDS SERVICES	**Frequency**	**Percent**
Discrimination	14	31.1
Stigmatization	16	35.6
Long Distance	5	11.1
Cost of Drugs	10	22.2
Total	45	100
ABORTION SERVICES		
Lack of access to prescribed drugs and experts to do safe abortion	3	6.7
Complications and loss of lives	2	4.4
Inability to pay for cost of abortion	12	26.6
The unfriendly attitude of health personnel	9	11.1
Stigmatization	4	8.9
Communication Barriers	19	42.2
Total	45	100.0
FAMILY PLANNING/CONTRACEPTION		
Lack of disability friendly structures	11	24.4
Long distance to facility	5	11.1
Communication Barrier	29	64.4
Total	45	100.0
ANTENATAL CARE		
The facilities are not disability user-friendly	14	31.1
Communication barriers between service providers and deaf	3	6.7
Distance/Transport Barriers	28	62.2
Total	45	100.0

Source: Client Exit Interviews

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From the table above, the greatest challenges restricting access to HIV/AIDS services by PWDs are Stigmatization (35.6%); Discrimination (31%) as well as Cost of Drugs (22%). The greatest challenges that limit access to abortion services by PWDs include: Communication barriers (42.2%); Affordability (27%) and the unfriendly attitude of health personnel (11%). For Family Planning services/contraceptives, the major challenges include: Communication Barrier (64%) and 'lack of disability friendly structures' (24.4%). Under Antenatal care, the main challenges include: Distance/Transport Barriers (62%); and that 'the facilities are not disability user-friendly'.

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4.4 Disability and accessibility of sexual and reproductive health services

The first objective of the study was to assess the accessibility of sexual and reproductive health services to PWDs at service delivery points. This was done taking into cognizance the main disability groups found in the study area including; physical disabilities, hearing/speech disabilities, sight disabilities as well as those with mental disabilities. The following findings were established:

4.4.1 Poor Physical Accessibility of Services

As indicated in Figure 4.2 on page 60 above, 51% of the respondents were persons with physical disability who provided specific information regarding access to sexual and reproductive health services. Besides, the data was further supported by information derived through Focus Group Discussions, Service Provider interviews and as well as Observation at Health Facilities. Figure 4.6 presents the summary of the findings.

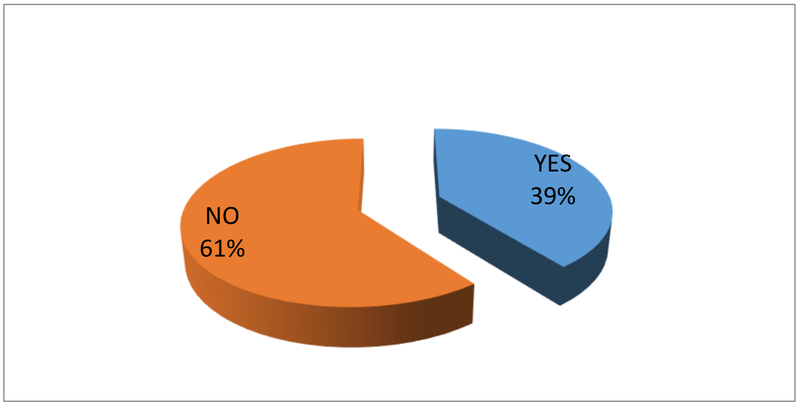

Figure 4.6: User friendliness of Facilities to PWDs

Source: Client Exit Interviews

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From Figure 4.6, majority of respondents (61%) indicated that SRHS were not user-friendly to them whilst 39% agree that such services were user–friendly or accessible to them. A probe sought to find out further explanations behind the responses. The ensuing explanations revealed that in general, all disability types are affected by physical inaccessibility especially as it relates to distance/transportation barriers to SRH facilities. For those with physical or mobility impairment, SRH accessibility was said to be hampered by issues related to distance to facilities and architectural barriers. As regards to those with visual disability ,challenges related to distance, unfriendly architectural designs, absence of large print signage and materials , absence of braille signage and materials among others did not make SRH facilities user-friendly. In respect of the hearing /speech impaired, issues of communication barriers, the absence of visual emergency alarm systems and transport/distance barriers were the factors militating against access to SRHS. Similarly, for those with mental disability, inaccessible SRHS was said to be occasioned by communication barriers, transport barriers, unfriendly attitude of service providers and other service users and stigmatization.

4.4.2 Physical / Architectural Barriers

One critical consideration in this study was finding out how architectural designs of SRHS delivery facilities influence patronage by PWDs. For those respondents indicating they have problems of accessibility, further probe was to find out reasons for inaccessibility of Sexual and Reproductive Health Facilities/Services. Findings show that slightly more than half (51%) of respondents cited unfriendly physical facilities as inimical to their ability to access SRHS. They mentioned the absence of ramps (91%); 'unfriendly' concrete steps at service facilities; narrow spaces at corridors; difficulty in accessing consulting rooms; absence of personnel to assist persons with physical disabilities to climb stairs; absence of wheel chairs/tricycles and absence of disability friendly beds in case of delivery or admission (9%). Figure 4.7 summarizes the findings.

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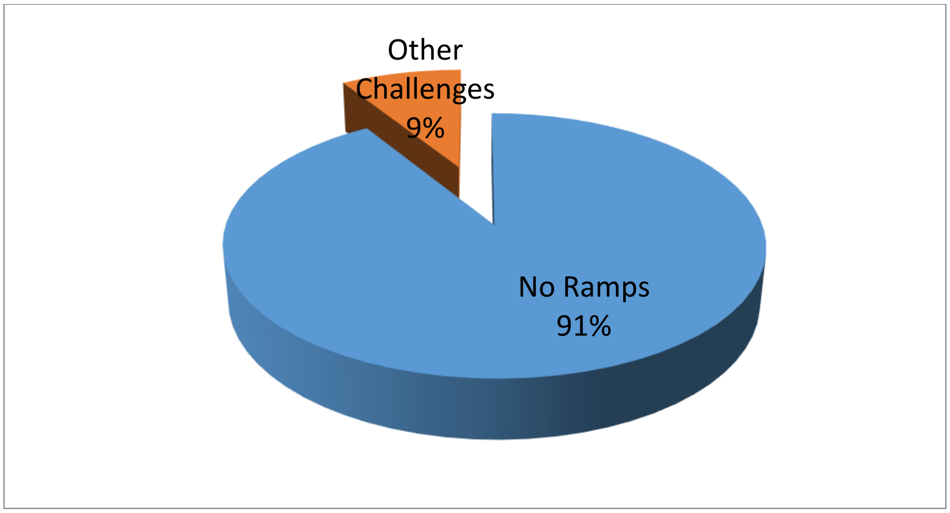

Figure 4.7 : Challenges that hinder services

Source: Client Exit Interviews

Since the absence of Ramps featured prominently in the issue, further efforts were made to explore the physical situation on the ground. In this sense, a checklist developed was used as the tool for observations for assessing SRH facilities in this study. One observation was aimed at recording facilities with the provision of ramps and those without ramps (Figure 4.8).

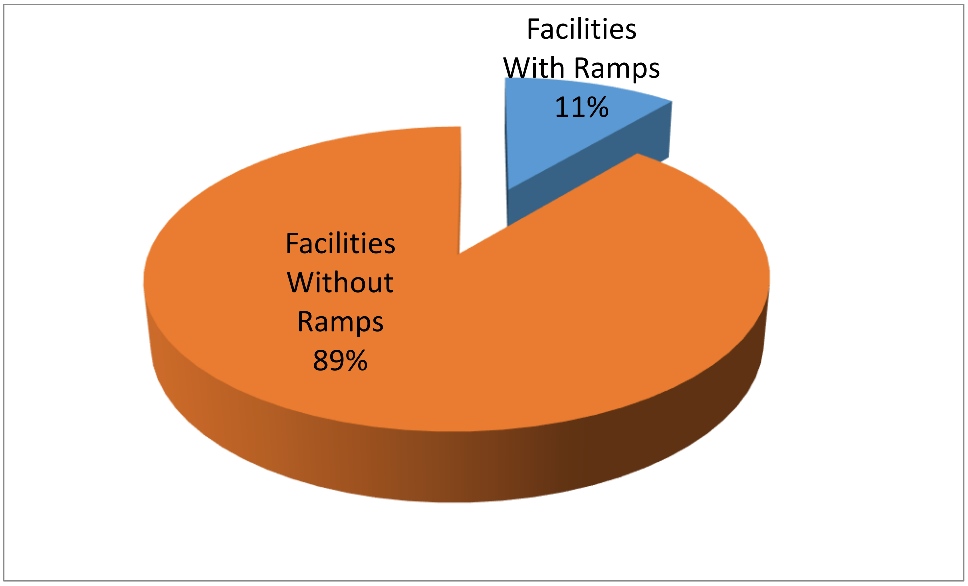

Figure 4.8 : Facilities with Accessibility Provision

Source: Health Facility Observation

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The findings indicate that 11% of health facilities have provisions for accessibility whereas the overwhelming majority (89%) has no provisions of ramps for accessibility. It was also discovered that apart from the absence of ramps, other basic facilities needed to make SRH facilities disability inclusive were generally absent. To bring further explication on the issue, some remarks made by participants at Focus Group Discussions (FGDs) on the issue have been highlighted below:

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> *It is absolutely dehumanizing for wheelchair user like me to access SRHS at health facilities. There are no provisions to enable me move independently whilst seeking health care services in almost all the health facilities. One gets to the health facility and do not only get stranded but goes through a time of hell to be able to see the doctor* (A 39 year old physically challenged male person from Kugzua).

Another FGD participant blamed the situation on the architectural design as follows:

> *It is regrettable to go for ANC only to detect that the facilities are so unfriendly and dangerous to the physically disabled. The steps are restrictive to movement and the delivery beds are difficult to climb. It is a nauseating and discouraging experience (*Female of 30 years, a physically challenged from Dabilla*).*

In-depth interviews with service providers have also confirmed the observations of PWDs generally. One Service Provider has this to say on the issue:

> *Most health facilities have been designed without any provisions for persons with disabilities. As health providers, we have difficulties dealing with PWDs who come to seek our services. Too much time is spent assisting them to access our services at the expense of other patients in waiting queues. We have made several appeals to the health authorities for the environment to be modified but to no avail (A 45 year old Service Provider of Quality Medical Centre).*

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4.4.3 Distance and Transportation Barriers

The utilization of SRH services by PWDs is informed by a number of factors of which distance and mode of transport is key. As indicated in table 4.2 above, distance/transport barriers has been identified by the study as an obstacle that impedes accessibility of HIV/AIDS, Family planning/contraception and ANC services by PWDs. As seen in the table, 6.7% of respondents, 11.1% of respondents and 62.2% of respondents identified distance/transport barriers as a challenge in accessing HIV/AIDS, Family Planning/Contraception and ANC services respectively. SRHS outlets/ facilities were said to be far from homes and this coupled with the lack of means of transport presents a huge challenge to persons with disabilities to access SRH services. Also, during FGDs, one participant pointed out that:

> *I know that ANC must be observed monthly but sometimes, I can't just make it in view of the distance. It is difficult and tiresome to reach the health facility on a wheelchair as the road is sandy. Sometimes I hire a motor-king*[1] *as means of transport but it costs money and secondly, motor-kings in the area always overload, making it a risky experience (A 29 year old female person with physical disability from Worikambo).*

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A 32 year old male (Person with Physical Disability) explains that in discussing SRH issues, the subject of affordability should be looked at not from the angle of direct pricing of the service per se (which is usually relatively low) but from associated costs including distance, inconveniences and transportation.

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[1] Motor-king is a tricycle motor found especially in rural areas and towns conveying passengers

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> *Certainly it may not be costly at all to buy a condom. But aside the money for the condom, a seemingly short distance for some people may be threatening and frightening to PWDs. To buy a condom for example, PWDs must bear the social cost of having an escort. In most cases, there is no confidentiality. PWDs become open books and gossip is generated. There is also the issue that the PWD must travel with the escort and pay the fare to the place where condoms are sold. You see, it is even much more expensive for the PWD than others to buy just a condom. This very reason limits contraceptive access and use* (A 32 year old male person with disability from Kugsabla).

4.4.4 Waiting Time at the Health Facilities/Procedural Barriers

Respondents cited long queues in health facilities which call for long waiting time for accessing SRHS as a challenge that bedevil PWDs. In a Focus Group Discussion, a respondent noted:

> *Long queues at service delivery points make me scared of going for ANC. Waiting for long hours in this condition of mine is extremely tiresome and frustrating. I sometimes stay back when I imagine that ordeal… (A 38 year old* Female PWD from Kugashiegu).

The FGD participants were worried about time spent waiting in the queue to see the service provider which results in fatigue. This is exacerbated by the physical limitations associated with disability and lack of positive discrimination by the health workers where PWDs are mixed with those who do not have disabilities. Persons with sight disability especially feel neglected in such situations.

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> *It is cumbersome for a person with sight disability like me to follow the procedures at health facilities. Following the queues and locating one's seats at health facilities is quite difficult. People push you around; on your own, you cannot tell when to move where; how you know the time to shift in the queue*
>
> *(*A 36 year old male person with sight disability from Gagbiri).

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4.4.5 Lack of Assistive Devices

The inability of PWDs to have access to assistive devices such as mobility aids like wheelchairs, crutches, tricycles as well as ortheses and prostheses was mentioned as another major concern that militates against their access to SRHS. A 27 year-old female PWD has this to say:

> *It is also the issue of mobility aids to go to service delivery points. If you cannot go then you have to sometimes depend on family members and friends. But they also have their lives to live; they have work and children to look after and cannot be available always for you. Even where they agree to help, how do you ensure confidentiality? We have no secrets when it comes to use of SRHS (Female PWPD, aged 27from Kpatia community).*

In the same vein, Service Providers said they were equally aware and disturbed about the challenges that face PWDs in accessing health facilities generally but sometimes feel overwhelmed and helpless in giving the necessary support. One Service Provider noted that:

> *In this health facility, the non-availability of assistive devices like the wheelchair greatly hampers our ability to satisfactorily attend to persons*

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> *with severe physical conditions. They are lifted at every stage of the service delivery process. This is not easy" (Service Provider from Worinyanga Health Centre).*

4.4.6 Communication Barriers

As seen in table 2, respondents identified communication barriers between service providers and service users as posing impediments to the accessibility of SRHS to PWDs. The dearth of sign language skills on the part of Service Providers for example was said to have a major adverse effect on communication with the hearing/speech impaired persons seeking SRHS at health facilities. In a FGD, one participant stated:

> *I don't like going for ANC regularly because I do not understand what the midwife wants to communicate. No matter how I try, it is difficult to understand… Sometimes going to ANC is not that helpful at all when the real reason is to understand* (Female PWD with hearing disability from Salugo).

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The situation is not limited to ANC service points but has implications for all other health services generally. Fati, (a Female Person with hearing disability) explains her own predicament:

> *I have stopped going for family planning services due to communication difficulties with service providers. We are unable to communicate at all: indeed they have many other people and they cannot afford to spend so much time with you alone… (Female Person with hearing disability from Dusbuliga).*

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Service Providers interviewed confirmed that they had communication barriers with the speech/hearing impaired persons seeking their services. One Service Provider discussing the issue observed that:

> *The situation is rather unfortunate. Much as you would want to do something fulfilling, you are limited as a health worker because you do not have the skills to communicate with hearing/speech impaired persons. We have no sign language interpreter in our facility, our best cannot be enough ... (Service provider from Rabito Clinic).*

4.5 Knowledge, attitudes and practices relating to sexual and reproductive health among respondents

One important study objective was to assess the knowledge, attitudes and practices regarding SRH services among respondents. This is based on the idea that people with knowledge about health issues are more likely to develop favourable attitudes that could engender positive disposition towards health services. In this study therefore, respondents were asked to indicate their awareness about existing sexual and reproductive health services in their localities. Figure 4.9 presents summary of the findings:

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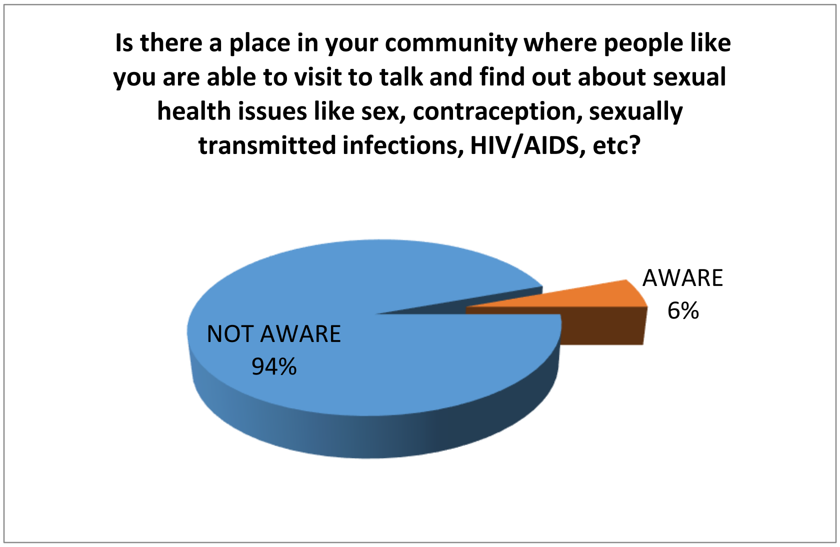

Figure 4.9: Respondents' Awareness of Existing Services

Source: Client Exit Interviews

Figure 4.9 shows that the overwhelming majority of respondents (94%) are not aware of at least one facility that provides SRH services. In the FGD, even participants who were aware of such services in their locale said they have not accessed these services. In the FGD, the following responses were recorded:

> *I do not have an idea where to have family planning, contraceptives or abortion services in our community. I doubt if any of such services exist in our community, even if such services exist, I am yet to know where …*
>
> *(Male person with hearing/speech disability from Kugpiella)*

Other participants at FGDs noted that even though they heard about the service delivery point in their locale, they were not able to visit the place for services. Accessibility becomes a problem especially for persons with hearing/speech disability.

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> *I have heard about family planning services and would want to visit there. But how to get there on my own is a challenge. What would people think of you? How do you get there without help from others? How do you ensure that you go there alone and do not have many other people hearing your secret, your privacy? (Female person with hearing/speech disability from Nagani: sign language)*

But some Service Providers hardly appreciate the situation.

> *The hearing/speech impaired persons in this community hardly come for family planning services. I do not know what the problem is. They are not interested in our services and hardly take the opportunity offered. Yet they are sexually active and, come to think of it, are the most vulnerable* (Service Provider, Worinyanga Health Centre).

The research further employed the Pearson chi-square test to investigate the association between disability types, educational levels and knowledge on sex, STIs and reproduction. The results were summarized in table 4.3 below:

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Table 4.3: Association of disability types, educational levels and knowledge on reproductive health

Variable	Will a girl stop growing after she has had sexual intercourse for the first time (Knowledge on Sex, STIs and Reproduction)						
	YES		**No**		**Don't Know**		**P. Value**
Disability	**n**	**%**	**n**	**%**	**n**	**%**	
Physical	5	(55.6)	12	(44.4)	6	(66.7)	
Visual	3	(33.3)	6	(22.2)	1	(11.1)	
Hearing	1	(11.1)	4	(14.8)	2	(22.2)	
Mental	-	-	4	(14.8)	-		
							0.713
Educational Level							
Basic	13	(39.4)	-	-	2	(25.0)	
Secondary	5	(15.2)	4	(100)	1	(12.5)	
Technical/Vocational	2	(6.1)	-	-	1	(12.5)	
None	13	(39.4)	-	-	4	(50.0)	
							0.012

Source: Client Exit Interviews

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From table 4.3 above, the p-value of 0.713 was established for all disability types combined, indicating the association between knowledge on sexual and reproductive health and disability types as being independent of each other. In other words, since the p-value is higher than 0.05, the association between the two variables (knowledge on sexual and reproductive health; and disability types) is statistically insignificant and hence, it can be said that the type of disability of a person has no influence on his/her knowledge on sexual and reproductive health. However in respect of the relationship between level of education and knowledge on sexual and reproductive health, 0.012 p-value was obtained and this amply indicates that the level of education influences knowledge on sexual and reproductive health.

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4.5.1 Illiteracy as a challenge

Generally, as shown in figure 4.4, the study revealed high illiteracy among PWDs. The hearing/speech impaired persons in particular were noted to be the hardest-hit by illiteracy in the study area. During FGDs with hearing impaired persons and interviews with service providers, responses lent credence to the effects of illiteracy on accessibility of sexual and reproductive health services. John, a male person with Disability has this to say on the issue:

> *Most of us who are hearing/speech impaired cannot read and write. It is difficult for most families in this predicament to think of a child with this problem first before others without the problem. The situation is particularly difficult because those with such a disability can only be sent to special schools that are very far and in most cases unaffordable to most. Most of us are unfortunately illiterate so reading to know more*

> *about SRHS and how to access such services is just difficult (Male person with disability from Avosum).*

Health providers interviewed also confirm the peculiar nature of the challenges facing especially the hearing/speech impaired persons in relation to reliable sources of information on SRH programmes.

> *The hearing/speech impaired persons who visit our facility for SRH services are unable to read or write. This makes it difficult for us to deal with them. The challenge is a big one … effective communication is an issue (Service Provider, Quality Medical Centre).*

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4.5.2 Confidentiality as a challenge

The code of ethics of health workers specifies how to ensure quality of care to the sick. In this sense, healthcare providers are to follow ethics and treatment protocols in the delivery of their services. Ensuring confidentiality in health service delivery is a crucial aspect of the treatment protocol. The study interviewed respondents on the confidentiality of SRH services rendered in their localities. Figure 4.10 gives a summary of the findings:

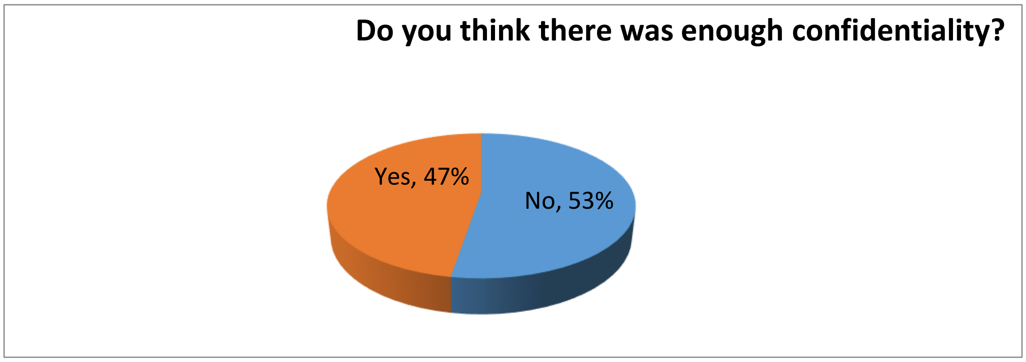

Figure 4.10 Responses on Confidentiality

Source: Client Exit Interviews

Figure 4.10 shows that more than half of respondents (53%) think that confidentiality in the facilities was a problem in seeking SRHS. It is equally important to note that quite a sizeable proportion of respondents (47%) think confidentiality was ensured during their visit to the health facility. The study further discovered that the hearing/speech impaired persons are more adversely affected by challenges related to confidentiality at service centers than other disability groups. A hearing/speech impaired mother noted:

> *It is a big problem to venture out to seek service in relation to sensitive issues like abortion, contraception and family planning. How do you present your worries without people turning against you? Even to discuss personal issues, we resort to someone between you and the service provider. For example, this interview demands an interpreter and likewise any other. Service providers cannot easily attend to us one-to-one, mostly they use other patients and family members to try to interpret our communications. How do you ensure your own safety in such situations?*
>
> (A 28 year old hearing impaired nursing mother, Pialogo)

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In-depth interviews with service providers likewise show frustrations with confidentiality especially because most service providers do not have the skills to communicate in the sign language.

> *Indeed, it is difficult to avoid a middleperson… This is especially in the case of hearing impaired persons seeking services. Sometimes we have to use family members and other patients to help us understand and attend to them* (Service Provider from Garu Health Centre).

4.5.3 Limited Access to Information

Access to information plays a pivotal role in educating and raising awareness on existing services including sexual and reproductive health services. This may influence the health seeking behaviour of people and inform choice of service. The study investigated the accessibility of information on sexual and reproductive health at service facilities to persons with disabilities. Table 4 gives a summary of the results.

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Table 4.4: Responses on Access to health information

At the service delivery point that you last visited, did you see posters on contraception?	Frequency	Percent
Yes	12	26.7
No	33	73.3
Total	**45**	**100.0**
Were you given brochures on contraception?		
Yes	2	4.4
No	43	95.5
Total	**45**	**100.0**

Source: Client Exit Interviews

From the table, majority of respondents (excluding the visually impaired) stated that they did not see posters and were not given brochures at SRH facilities. This implies limited exposure to printed messages on SRH at health facilities.

The case of the visually impaired was a rather peculiar one. Indeed all respondents in this category said they feel generally cut off completely. Madam Mariama (A 31 year old female person with sight disability) explained their frustration further:

> *Sexual and reproductive health information available at service delivery points are not written in the appropriate way for those of us who are visually impaired. We cannot read them (A female person with sight disability from Worikambo).*

The study further investigated the preferred source of accessing SRH information by disability types. Also, the Pearson chi-square test for independence was employed to find out if type of disability had influences on individual's preferred source of SRH information. The Pearson test for independence was tested under the 0.05 significant levels, therefore any test results found to have a p-value less than 0.05 was considered statistically significant. The results were as follows:

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Table 4.5: Bivariate Analysis of Responses on Preferred sources of SRH Information

Variable	Preferred Source of Sexual and Reproductive Health Information												
Disability	**School**		**Family**		**Friends**		**Doctors**		**Books/Magazines**		**Radio**		**P-Value**
Physical	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
Visual	1	(100)	4	(36.4)	3	(50.0)	13	(61.9)	1	(50.0)	-	-	
Hearing	-	-	3	(27.3)	1	(16.7)	4	(19.0)	-	-	1	(100)	
Mental	-	-	1	(9.1)	2	(33.3)	2	(9.5)	1	(50.0)	-	-	
	-	-	3	(27.3)	-	-	2	(9.5)	-	-	-	-	
Educational													
Level													**0.665**
Basic													
Secondary													
Technical/Vo	-	-	4	(36.4)	2	(33.3)	7	(33.3)	1	(50.0)	1	(100)	
cational	-	-	2	(18.2)	3	(50.0)	3	(14.3)	1	(50.0)	-	-	
None	-	-	1	(9.1)	1	(16.7)	1	(4.8)	-	-	-	-	
	1	(100)	4	(36.4)	-	-	10	(47.6)	-	-	-	-	
													0.665

Source: Client Exit Interviewss

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Table 4.5 is a cross tabulation of type of disability and the respondents' preferred place or source of receiving information on SRH. As indicated in the table, only 1 person who said he/she preferred to receive information from a school was found to be physically challenged. Also, of those who said they preferred to get SRH information from their families, 36.4% were physically challenged, 27.3% were visually impaired, 9.1% had hearing disability and 27.3% had mental disability. Furthermore, out of the total number of respondents who preferred getting SRH information from friends, 50.0% were physically challenged, 16.7% had visual disability and 33.3% had hearing disability. Besides, no mentally challenged respondent preferred friends as their source of SRH information. The results also indicated that there were as many as 21 respondents in total who said they preferred a Doctor as their source of SRH information, of these, 61.9% were physically challenged, 19.0% had sight disability, 9.5% had hearing disability and 9.5% were mentally challenged. As indicated in the table below, only one each of the physical and hearing challenged persons preferred books/magazines as their source of accessing SRH information whereas none of the mentally and visually challenged respondents preferred that source of information. Similarly, only one visually challenged person preferred radio as source of SRH information; all other disability types did not choose radio as an option for getting their SRH information. Generally, the respondents most preferred source of SRH information was a Doctor. This was followed by family and friends. We further sought to establish whether type of disability had any influence on the respondents' preferences for source of information. The Pearson chi-square results revealed that the respondents preferences were independent of the type of

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disability (p-value >0.05), that is to say that type of disability had no influence on the preferences they made.

Similarly, the research explored the association between the educational levels of PWDs and their preferences in terms of the source of SRH information. As seen in table 10 above, the Pearson chi-square test yielded a result of 0.665 as the p-value. This amply suggests that the level of education had no influence on the preferences made regarding the sources of SRH information.

4.5.4 Stigmatization

From table 4.2, stigmatization has been identified as the greatest challenge confronting people seeking HIV/AIDS services in the study area. It was also discovered that stigmatization of PWDs equally affect access to ANC, Family planning /contraception and abortion services. During FGD, Amina (a 33 year-old woman with sight disability) explains:

> *I feel very uneasy attending ANC services because of stigma. The attitude of other ANC attendees as well as midwives leaves much to be desired. There is the general feeling of some sort of pity or even worry suggesting that a blind woman should not be pregnant. Sometimes I wonder why people think that we are different … so different as not to be counted normal in seeking usual concerns like marriage and children* (A woman with sight disability from Yizidug).

The case of those suffering mental disability is perhaps the most difficult to comprehend. A 29 year-old female (graduate of Bolgatanga Polytechnic and a person with mental disability*)* explains the predicament as follows:

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> *My situation now creates a lot of problems for me. All things have become very difficult because of the stigma. The attitude of people around affects me terribly. Indeed even for health workers, it is difficult to express your personal needs and feelings regarding sexuality. You are seen as abnormal and as such normal sexual urge is not to be considered as part of you at all. I suggest that service providers should be educated to accept that the sick are still human, with human needs (*A woman with mental disability from Tempane*).*

A further probe was to establish the relationship between the type of disability and attitudes towards people living with HIV/AIDS on one hand and that of educational levels and attitudes towards persons with HIV/AIDS on the other hand using the Pearson chi-square test. The results were as follows:

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Table 4.6: Association between Disability types, educational level and Attitudes towards people with HIV/AIDs

Variable	Should people who are HIV positive be allowed to take part in Church or religious activities? (Attitude towards People Living with HIV/AIDs)				
	Yes		**No**		
	n	**%**	**n**	**%**	**P-value**
Disability					
Physical	19	(55.9)	4	(36.4)	- -
Visual	8	(23.5)	2	(18.2)	- -
Hearing	3	(8.8)	4	(36.4)	- -
Mental	3	(8.8)	1	(9.1)	- -
					0.277
Educational Level					
Basic	13	(38.2)	2	(18.2)	- -
Secondary	4	(11.8)	6	(54.5)	- -
Technical/Vocational	1	(2.9)	2	(18.2)	
None	16	(47.1)	1	(9.1)	
					0.003

Source*:* Client Exit Interview

From the table 4.6 above, the disability types namely physical, visual, hearing and mental all together has a p-value 0.277.This means that disability has no influence on the attitudes exhibited towards people living with HIV/AIDS. Similarly, the p-value for

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educational level 0.003 is statistically significant as it is less than 0.05, hence, the study established that educational levels of individuals has a strong influence on the attitudes exhibited towards people with HIV/AIDS.

4.5.5 Negative Attitudes of Service Providers

The attitude of service providers is seen as an important factor in quality of service provision generally. In this study therefore respondents were asked to indicate whether they feel comfortable with service providers generally. The findings suggest that PWDs are sensitive to attitudes of service providers generally. Negative attitudes exhibited by service providers towards PWDs inhibit patronage of sexual and reproductive health services in the study area. An unfriendly attitude of service providers was cited by 11.1% of respondents interviewed as inimical to their ability to access sexual and reproductive services. Also, the results from FGD confirmed this finding:

> *Anytime I go for family planning or ANC, the attitude of the service provider is one of hostility. I often feel upset especially at the level of impatience exhibited by service providers towards me. May be I should stop going to them for any help* (A woman with sight disability from Tendanin)

Another participant of the FGD had this to say:

> *The way the midwife behaves towards me scares me from going in for skilled delivery. You can't imagine that even in the excruciating pain of labour, shouts and insults are common. In view of this I prefer to be delivered at home by a TBA* (A female person with physical disability from Gbanterago)**.**

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4.6 Economic and other factors influencing service accessibility by persons with disabilities

The study also investigated into economic and other factors that influence the accessibility of SRH services by persons with disabilities. The findings were as follows:

4.6.1 Economic Barriers

The cost of SRHS limits the ability of PWDs to access such services in the study area. As seen in table 4.2, 22.2 % of respondents cited cost of drugs as an obstacle to their access to HIV/AIDS services whilst 26.6% also stated that their inability to pay for abortion services limited their access to abortion services. A further investigation reveals the following response:

> *The cost of abortion services is high and difficult to afford. The National Health Insurance Scheme (NHIS) which is meant to help us the poor is no longer effective. You may have the NHIS card and yet you have to buy some drugs for treatment* (A female person with physical disability from Tubong).

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The study also established that the cost factor influences the choice of abortion method that PWDs will opt for. Figure 4.11 gives a summary of respondent's preferred method of abortion:

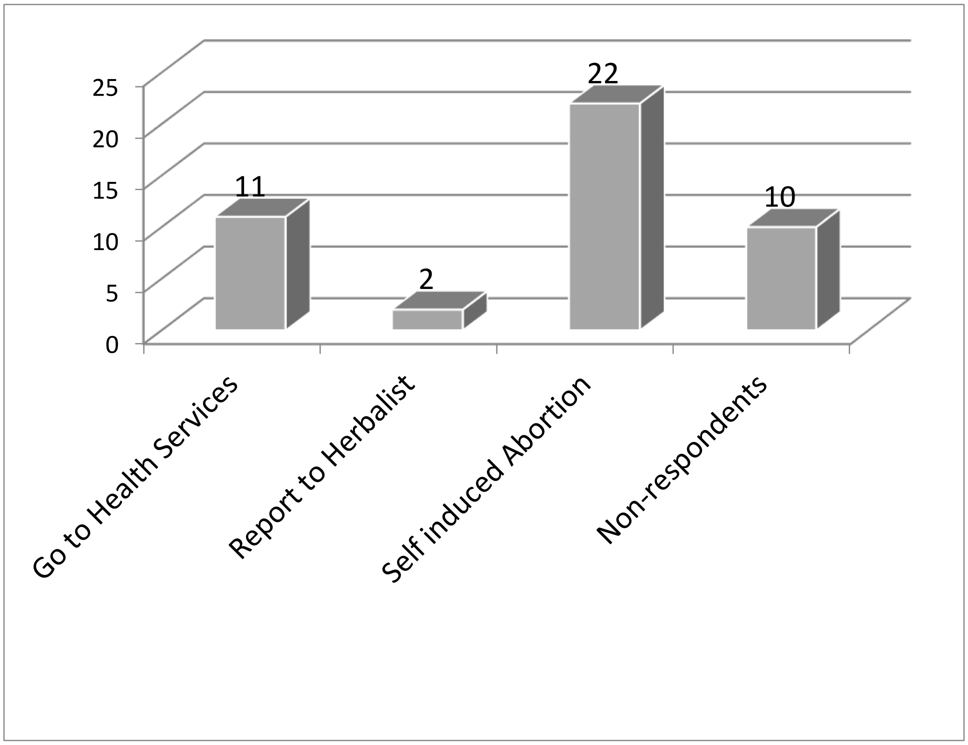

Figure 4.11 : Respondents' Choice of Method of Abortion

Source: Client Exit Interviews

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From the chart above, majority of respondents would prefer self-induced abortion to any other methods as indicated. Respondents revealed that self-induced abortion was less expensive and more confidential hence their choice.

Likewise, the study also sought to know the preferred method of delivery of respondents. The result was as follows:

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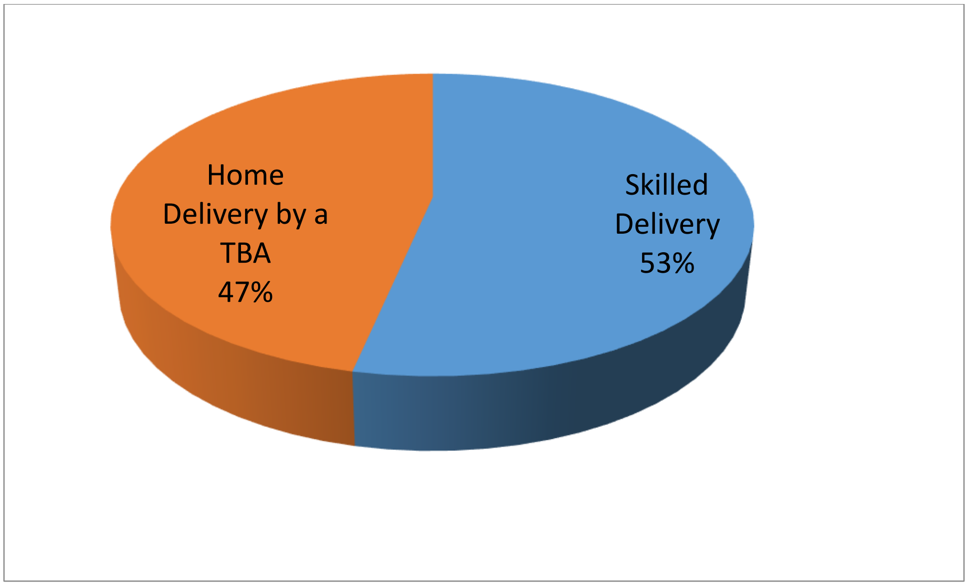

Figure 4.12 : Respondents' Preferred method of Delivery

Source: Client Exit Interviews

From the Figure, 47% of respondents opted for home delivery by a TBA as their preferred choice of delivery whilst majority (53%) opted for skilled delivery by midwife. A further investigation was conducted to unravel the reasons for the respondents’ choice of delivery and this gave the following results:

Table 4.7: Reasons for Respondents’ Choice of Place of Delivery

Give reasons for your choice of delivery	**Frequency**	**Percent**
It is safer at the health facility since they are skilled	20	44.4
Home delivery is less costly	12	26.6
Home delivery so as to avoid stigmatization from others	8	17.7
At the health facility Midwives can manage complications	5	11.1
Total	**45**	**100.0**

Source: Client Exit Interview

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From the table, the reasons assigned for the choice of skilled delivery by respondents is that they believe it is safer as trained personnel can manage any complications that may arise. Majority of those who opted for home delivery by TBA attributed their choice to cost of delivery (In their view, home delivery is less costly).

More to the point, during a FGD, a respondent stated:

> *Midwives demand that we come with so many items including clothing, gloves, cotton wool, panties, soap etc. and this makes skilled delivery expensive compared to home delivery by a TBA (A Woman with physical disability from Yabrago).*

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4.6.2 Side effects of Family Planning & Abortion

The side effects of family planning and abortion were mentioned by respondents in FGD as an obstacle that limit them from accessing SRHS. The following were the responses:

> *The use of family planning methods come with their own effects. Excessive bleeding and sometimes suspension of the menstrual cycle leading to inability to conceive has been the experience of some of us. This does not encourage us to go in for family planning services"* (Female person with sight disability from Zoatrikuom)

Another participant of FGDs noted:

> *I personally will not want to practice abortion because of side effects. I have seen expecting mothers bleed to death after abortion. I have also seen others becoming barren after several abortion attempts. It is not safe to practice abortion* (A female with mental disability, Nate).

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4.6.3 Use of local herbs and concoction

Findings show that self-induced abortion is widely practiced by PWDs in the study area. The researcher probed into the materials that are used to conduct abortion in the study area. The results were as follows:

Table 4.8: Materials used for abortion practice in the study area.

What materials do people use to conduct abortion in your community?	**Frequency**	**Percent**
Health facility and its gadgets	1	2.2
Local Herbs and Concoctions	23	51.1
Abortion drugs from chemical shop	21	46.7
Total	**45**	**100.0**

Source: Client Exit Interview

From the table above, the majority of respondents indicated that people use local herbs and concoctions to conduct abortions in the study area.

Responses from FGD revealed the following regarding the use of herbal medicine in place of skilled abortion services:

> *It is less expensive to use herbal medicine for abortion purposes than to go to the clinic. Many women prefer this approach because of privacy and cost considerations* (Female person with physical disability from Dabilla).

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CHAPTER 5

DISCUSSION

5.0 Introduction

This chapter presents the discussion of the research findings as seen in chapter four. The findings are interpreted and linkages are drawn using literature in the area of study.

5.1 Demographic Factors Influencing Service Accessibility by Persons with Disabilities

The study established that demographic variables such as age, gender, disability, marital status and religion have influence on accessibility of SRH services by PWDs in the study area.

As regards to age, the study established that respondents between 15-19 years were the least to patronize SRH services in the study area. Majority (78.6 %) of those who made use of SRH services fell within the 30-39 age. This implies that early adolescents in the sample largely shy away from SRH services. This finding concurs with the findings of Bender (2013) and that of Ong et al., (2012) that young people especially those with disabilities generally have peculiar needs and that appropriate strategies should be adopted to reduce barriers and make SRH services more appealing to young people. It also lends credence to the works of Braeken (2012) and Alli Maharaj (2013) that access to services is a central concern for young people generally and that a holistic approach tailored towards addressing sexual and gender based violence, sexual diversity, discrimination, relationship issues (interpersonal relations between service providers and young persons), fears and concerns about sex and sexuality should be pursued.

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In terms of gender, the study established that more females with disabilities go for SRH services than males with disabilities. This finding is in consonance with the finding established by the WHO (2013) that females are more likely to use modern contraception than the males due largely to limited male contraceptive methods.

Moreover, in respect of disability, the study discovered that more persons with physical disability utilize SRH services in the study area than other disability types like the hearing/speech impaired, the visually impaired and the mentally challenged. This implies that there are peculiar barriers pertaining to each disability type in the area which determines or influences utilization of SRH services. For example, the study discovered that the hearing/speech impaired was less affected by inaccessible physical structures as compared to those with sight and physical disability (McKay-Moffat, 2007). For the hearing impaired, their greatest obstacle was related to communication barriers between them and service providers and other service seekers at health delivery points. This agrees with the findings of earlier studies conducted in Ghana that revealed that generally the deafin an attempt to access SRH services encounter numerous barriers such as problems with communication, ignorance about deafness, negative attitudes, and services that are not customised to their needs(Mprah, 2013). Similarly, for the mentally challenged, the study discovered that their greatest obstacle to access to SRHS lies in the stereotypes and the stigma that they encounter and had to endure generally at service outlets; this explains why they were found to be least in utilizing SRHS as seen in figure 2. This is related to the findings established by earlier research works that stereotypes surrounding this category of persons with disabilities have resulted in the misconception that they have no sexual needs and are ignored (NWCI,2006;Priestly 2000) or that they

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are abnormally fertile and conduits for spreading STIs and subjected to coercive sterilization or forced contraception (NDA, 2007).

Also, with regard to marital status, the research established that the married PWDs utilized SRH services than the unmarried/single, widowed or divorced. Conversely, unmarried persons with disabilities patronized abortion services than the married. These findings correspond with the behavior of adolescents generally. Guttamacher (2015) for example found among other things that married adolescents in Latin America and the Carribean go for contraception than the unmarried due to the fact that the unmarried were likely to have less frequent sex and had to face a lot of stigma when seeking contraception. The high use of abortion services by unmarried PWDs is understood in the social and cultural context of the study area where pregnancies by the unmarried is frowned, compelling the victims to get married or engage in abortion.

As regards to religion, the study discovered that the religious affiliation of PWDs influence their utilization of SRHS. As seen in figure 5, majority of PWDs (69%) who reported to service outlets for services were Christians. A further probe revealed that Christianity shuns against practices such as multiple sex partners, encourages marital fidelity and the need for married couple to always gratify their partners sexually; hence the married Christian population resort to the use of contraceptives to check unintended pregnancies in their quest to meet their sexual needs. This corresponds with the findings of Kehinde (2013) that Christians are more receptive to contraceptive use in Nigeria than other religious groups or sects.

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5.2 Poor Physical Accessibility of Services

The study findings revealed that PWDs are unable to access and utilized sexual and reproductive health services because of poor physical accessibility of service facilities. Physical barriers such as long distances to service facilities, high cost of transport, the absence of ramps to ease accessibility by the physically disabled coupled with the lack of assistive devices to aid movement have all been identified as obstacles that impede the accessibility of SRHS in the study area. Again, intra-facility accessibility constraints such as narrow corridors, unfriendly steps, the lack of adjustable delivery beds in maternity wards, absence of wheelchairs and long waiting queues,all contribute to the inability of PWDs to access and utilize sexual and reproductive health services in the study area. These findings lend credence to the work of Smelterz (2007) who suggested that health providers seem to be oblivious of the challenges that “inaccessible offices and clinics” present to the disabled. The findings also agree with the works of Kaplan (2006) who asserted that the presence of architectural barriers which impede access convey an impression to women with disabilities that they are “unwanted, unwelcome and are a burden on health care providers”. This implies that the availability of SRH outlets or facilities does not necessarily mean that SRHS will be utilized by all segments of the population. The specialized needs of PWDs need to be considered to ensure balanced and a well -integrated service delivery.

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5.3Limited Knowledge of Service Providers and Service Users

The lack of knowledge about SRHS has been identified by the study as a bane to access and utilization of SRH services in the study area.

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The study established ignorance on the part of service users as impeding the utilization of SRH services in the study area. The study revealed that majority of PWDs are unaware of the existence of SRH services in their locations even though such services actually exist. The absence of posters, drawings and sign boards serving as pointers to the availability and location of existing SRH services in various communities have been noted in other studies as partly culpable for the level of ignorance and non-utilization of services such as contraception, family planning, abortion, ANC and HIV/AIDS. PWDs are generally at the risk of HIV infection than their non-disabled counterparts due to low awareness levels of HIV/AIDS, ignorance and vulnerability to sexual abuse(NUDIPU, 2004).The educational levels of persons with disabilities in the study area have also been identified to have an influence on knowledge about SRH.As noted in table 4.3, the study associated educational levels with knowledge on SRH through the deployment of the Pearson Chi-square test and established that educational levels of PWDs has a strong association with their knowledge on SRH. This finding is consistent with the results of previous studies; for instance Mustafa et al., (2015) noted among other things that educated women are more likely to be aware about the importance of health services and more able to select the most appropriate service for their needs. In addition, educated women have more opportunities to enter into the labour market, and therefore have access to financial resources and more decision-making power.

In the case of the visually impaired, information about SRH services is not useful as such pieces of information are not designed and presented in appropriate formats and in braille to enable them use them. These findings affirms that of Nzegwu (2004) who noted that the preponderance of vision-impaired women do not receive any health information in apt

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and useful formats and that of the findings of Commission for Healthcare Audit and Inspection (2008) which observed that having in place an accessible information that customizes the needs of the visually impaired continuous to be a challenge.

Also, the limited knowledge and capacity of service providers to effectively communicate with service users especially the hearing/speech impaired persons has been identified by the study as posing a challenge to service utilization. The study established that service providers are unable to communicate directly with service users through sign language because they have not been trained in sign language skills. Again, the study revealed that most service users such as the hearing/speech impaired were illiterates and hence communication with service providers in writing is also difficult. Service providers under such circumstances often resort to the use of interpreters, mostly other patients and family members to bridge the gap of communication to be able to understand and attend to them. This implies that the hearing/speech impaired persons are left unattended to where there is no interpreter or they are attended to unsatisfactorily. Secondly, the involvement of other patients, families and friends of PWDs as interpreters to a large extent often compromise the confidentiality principle of healthcare provision and serves as a hindrance to service utilization. These findings concurred with that of Steinberg (2006). He observed that the hearing impaired do not feel respected or supported when interfacing with healthcare professionals. Until a panacea is found for this nostrum, the quest for the hearing/speech impaired persons to equitably access SRH services in the study area will essentially remain a mirage.

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5.4 Negative Social Attitudes

Negative attitude of health care providers emerged as a key challenge to access and utilization of SRH services in the Garu-Tempane District. Bad treatment meted out to PWDs at health facilities including the use of abusive language by health care providers featured prominently in the findings. This, coupled with the stigmatization of PWDs at service points by other service seekers and the discriminatory practices of service providers, posed a huge challenge to PWDs' ability to access SRH services. This finding agrees with the works of Massie (2006) who identified negative attitudes to disability as the major barrier to disabled peoples' full participation in society. It also concurs with findings established by the American College of Obstetricians and Gynecologists (November, 2014) that "Stigma, harassment, and violence discourage abortion access and provision".The negative attitude of health care providers and other service seekers was linked to the myth that PWDs should be asexual, especially women with disabilities who were not expected to become pregnant.The study established that in view of negative attitudes, PWDs are unwilling to go for SRH services such as family planning, HIV/AIDS services, ANC, skilled delivery and safe abortion practices. These attitudinal barriers account for the high incidence of self-induced abortion and that of unskilled delivery practices (Iqbal , 2014). This is in line with the finding of the American College of Obstetricians and Gynecologists (2014) that the stigma of obtaining an abortion, as well as for providing an abortion, may lead to secrecy, marginalization of abortion from routine medical care, delays in care, and increased morbidity from the procedure. PWDs are opting for self-induced abortion and unskilled delivery practices whichare risker than safe abortion and skilled delivery just to circumvent stigma.

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Indeed this finding is contrary to the provisions of the Ghana Disability Law (Act 715 of 2006) that states, inter alia, that persons with disabilities should be given the opportunity to enjoy the same rights with other members of the public in all health institutions, and that health professionals provide care of the same quality to PWDs.The findings call for the fostering of positive attitude among health care providers to appreciate the needs of PWDs as regards to sexual and reproductive health.

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5.5 Economic Barriers / High Cost of Services and Alternative Care

The study revealed that quite a good number of PWDs (31%) were unemployed as seen in Table 4.1. As indicated, of those employed, subsistence farming was the main occupational activity engaged by PWDs. Income poverty is found to be a major challenge for accessibility of SRH services generally. Iqbal (2014) on abortion access reports that pronounced differences are found by economic status with poor women much more likely to have an abortion performed by unskilled providers than well-off women. This agrees with the finding of Centenary (2010) that poverty and low income levels negatively influences ANC attendance in Uganda. The findings equally agree with that of Philippi (2009) that high cost of services serves as an impediment to access and utilization of SRH services. High cost of services has also been implicated in people resorting to alternative care such as the use of local herbs and other home-made solutions to health problems. In a study on low ANC attendance, Mustapha et al. (2015) found thata major concern has been about affordability. Home delivery believed to be less expensive is preferred in communities than ANC services. The situation has been found by (Guttamacher, 2015) to be partly responsible for more vulnerability to the effects of risky and unsafe health practices.

CHAPTER 6

GENERAL CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

The section focuses on the summaries of the key findings and recommendations aimed at improving SRH service accessibility to PWDs as well as general conclusion of the research work.

6.1 Conclusions

The following are the conclusions drawn out of the findings and discussions of findings generally. This is anchored on the key findings established in relation to objectives of the study.

The utilization of available sexual and reproductive health services by youth with disabilities in the study area has been poor. This makes the youth with disabilities susceptible to STIs, unplanned pregnancies and unsafe abortion practices. The finding suggests that in order to reduce vulnerabilities of PWDs to STIs, the need for innovative strategies to reach PWDs in the Garu-Tempane District cannot be overemphasized.

The findings point to poor PWD male support for their spouses in accessing reproductive health services like ANC and skilled delivery in the study area. There is the misconception that SRH services should be borne by females. This registers a barrier for couple decision making in SRH services. There is the need for education on the issue so as to promote male support for services.

The finding that sexual and reproductive health facilities in the Garu-Tempane District are not disability inclusive is a major concern if efforts are to help improve service

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provision for PWDs. There is the need for management to explore ways of improving physical accessibility to these services.

Limited access to appropriate health information by persons with sight disability is another major concern in this study. The findings point to the need for SRH information to be presented in special formats to enable persons with sight disability to have SRH information at health facilities.

Poor knowledge about existing SRH services among PWDs was found to be responsible for poor utilization of services by PWDs.

Limited capacity on the part of service providers in terms of sign language skills to communicate effectively with SRH service users especially persons with speech/hearing disability hampers SRH utilization in the Garu-Tempane District. In view of this underlying problem, service providers fail to understand the needs of hearing/ speech impaired persons and services rendered are often unsatisfactory and mostly do not customize the needs of users.

There is high illiteracy among PWDs in the study area and this serves as an obstacle to utilization of SRH services in the area. This challenge has resulted in poor communication between service providers and service users as well as the limited use of available SRH information.

The study discovered negative social attitudes especially as it relates to stigmatization of PWDs at service delivery points as well as discriminatory practices exhibited by service providers and other non-disabled service seekers as inimical to the utilization of SRHS by PWDs in the study District. Thus, stigmatization and discrimination discourage and deter PWDs from utilization of SRH services.

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Majority of PWDs in the Garu-Tempane District are subsistence farmers and have limited income generally. In view of the limited nature of income they generate, they are unable to meet their needs including that of SRH needs. This coupled with high cost of SRH services serves as a bottleneck to service utilization.

There is high self-medication and especially the use of local herbs among PWDs in the area as an alternative to biomedicine due to high cost of SRH services. This exposes PWDs to all manner of risk including unsafe abortions and unskilled delivery; and their associated consequences.

To sum up, the study established that demographic variables such as age, gender, disability, marital status and religion influence the accessibility of reproductive health services by persons with disabilities in the study area. It was further discovered that access to reproductive health services by persons with disabilities were limited by systems factors including poor service delivery and lack of appropriate health services tailored to meet their needs. Also, economic, social and psychological factors were identified including lack of familial support, stigma and discrimination as barrier to access. Based on the findings, some recommendations have been proffered to improve the accessibility of reproductive health services by persons with disabilities.

6.2 Recommendations

The study findings revealed a number of gaps in the provision and utilization of SRH services by PWDs; gaps in information dissemination systems to PWDs, communication barriers between service seekers and service providers, economic, structural and organizational barriers relating to accessibility of SRH services among others. Against the background of the findings, the study came out with recommendations as follows:

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1. Strengthen Behaviour Change Communication/Advocacy

Civil Society Organizations operating in the study areamay consider strengthening advocacy to change the behaviour of the youth especially those with disabilities towards utilizing SRH services. In this direction, the Presbyterian Community Based Rehabilitation (CBR) programme may take up the lead role and team up with other CSOs in the area to vigorously disseminate information on SRH and the need for the youth with disabilities to patronize such services. This could be done through radio discussions and organization of community durbars in various communities within the study area. This will help reduce the vulnerability of the youth with disabilities to STIs, unplanned pregnancies and unsafe abortion practices.

Again, as negative attitudes such as discrimination and stigmatization of PWDs have been identified as posing a challenge to access and utilization of SRH services, it is recommended that the Ministry of Health in collaboration with the Presbyterian Community Based Rehabilitation (CBR) may design advocacy messages tailored towards changing the stereotypes of service providers and non –disabled persons towards the disabled at service delivery points. Posters and leaflets containing information about the rights of PWDs could be developed and displayed at service delivery points to drum home the need for inclusive health care delivery devoid of discrimination and stigmatization of PWDs.

2. Strengthen Gender Mainstreaming in Sexual and Reproductive Health Care Delivery

It may be useful for the Ministry of Gender, Children and Social Protection to team up with civil society organizations in the study area to educate communities about gender and disability issues and the need for male involvement in SRH services especially as it relates to ANC and skilled delivery attendance. The myth surrounding ANC and skilled delivery attendance as feminine activities that less concerns men could be dispelled through community sensitization. Thus, the male in the study area could be encouraged to take keen interest in maternity issues and to support their wives to access and utilize SRH services.

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3. Enforcement of Disability Law on Physical Accessibility

The Government of Ghana through the MDAs could enforce the disability law to make SRH services accessible to PWDs. The legal provisions on physical accessibility of services could be invoked to compel service providers to modify their service environments, facilities and structures to be disability friendly. There could also be measures put in place that ensures that new structures and architectural designs make provisions that are disability inclusive. These are necessary so as to ensure that services are physically accessible to PWDs at service outlets or points.

4. Design, Translate and Disseminate Health Information in Appropriate Formats

As the study discovered that the visually impaired persons in the study area do not find available health information useful, the MOH may consider designing, translating and disseminating health information more particularly as it relates to SRH in braille, large prints and in audio tapes to enable the visually impaired to access and utilize health information appropriately.

5. Incorporate Sign Language in Curriculum of Health Training Institutions

The government of Ghana through the MOH could develop and incorporate sign language skills in the curriculum activities of health training institutions. This will ensure that health providers such as nurses and doctors acquire basic sign language skills to be able to effectively communicate with PWDs especially the hearing/speech impaired who seek SRH services.

6. Recruit Sign Language Interpreters at Service Points/Outlets

It may be helpful for the Ministry of Health to recruit and assign sign language interpretersto SRH delivery facilities to ensure that there is effective communication between hearing/speech impaired persons seeking SRH services and service providers as an interim measure. This will bridge communication gaps and assist service providers to understand the SRH needs of hearing/speech impaired persons and adequately address such needs.

7. Conduct Regular In-service Training for service providers

In-service training to build the capacity of health workers could be organized regularly to enable them build their capacity in human relations, sign language ,treatment protocols and code of ethics of the MOH. The GHS and CHAG may develop regular in-service training programmes and make budgetary allocations for this to happen. This is particularly important to ensure that health workers are abreast of health issues and develop the right attitudes towards PWDs and other patients seeking their services.

8. Promote Inclusive Education for Persons with Disabilities

In order to address the high levels of illiteracy among PWDs, it is recommended that the MOE through the GES and the NFED may collaborate with NGOs and CSOs to promote inclusive education in the study area. The GES and the NFED could create the enabling environment to ensure that PWDs and their non-disabled counterparts can learn from the same settings without discrimination and marginalization. NGOs and CSOs may

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undertake advocacy to encourage parents/guardians to send CWDs to schools and provide capacity development to teachers to enable them handle CWDs in inclusive schools.

9. Improve Livelihoods Opportunities for Persons with Disabilities

In view of the state of poverty in the study area, people with disabilities could be empowered economically to enable them generate income to meet their socio-economic needs including meeting the cost of SRH needs. As farming is the main economic activity of the people in the area and due to erratic rainfall patterns with the telling on poor crop yields, it is recommended that the government and non-governmental organizations consider the provision of irrigation facilities to enable PWDs and their communities to engage in all year round farming which will lead to improvement in their incomes. It also recommended that the CBR programme in collaboration with MOFA and the Presbyterian Agricultural Station consider providing extension services which may include new techniques and skills of farming to enable PWDs and their families/communities improve agricultural production. Moreover, it is further recommended that the District Assembly in collaboration with the Presbyterian CBR programme should consider devoting the Disability Fund to train PWDs in vocational skills and petty trades /value addition and provide start -up capital for them to engage in businesses. This will reduce unemployment among PWDs and increase their income generation capacity. Once PWDs are able to initiate some business activities, the CBR programme could further mobilize them into SHGs and link them to rural banks and other cooperative societies to access credit for the expansion of their enterprises. When their

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incomes are improved it will impact positively on their ability to access and utilize SRH services.

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APPENDIX I

Physical Accessibility Checklist

Instructions for use:

Please answer every question. If a question is not applicable to the facility being surveyed, please put a check in the N/A column.

Please make comments on the accompanying comments page, referring to the question by number. Comments should include such information as to indicate "readily achievable" or not if the question rates a "no" rating.

Facility Name: ______________________________

Surveyor Name: ______________________________

Survey Date: ______________________________

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	Yes	No	N/A	
				Parking and Passenger Loading Zones *(ADAAG 4.6)*
1.				Are an adequate number of accessible parking spaces (96 inches wide for the vehicle plus a 60-inch-wide striped access aisle adjacent to the parking space) available?

Total Spaces	Accessible Spaces Required
1 to 25	1
26 to 50	2
51 to 75	3
76 to 100	4
101 to 150	5
151 to 200	6

	Yes	No	N/A	
2.				Are enough accessible spaces for lift-equipped vans (96 inches wide for the van plus 96-inch-wide striped access aisle for the lift) available? (At lease one in every eight accessible parking spaces should be van accessible. If there is only one accessible parking space, it should be van accessible.)
3.				Are the parking spaces closest to the building's accessible entrance accessible parking spaces?
4.				Are all accessible parking spaces identified by signs bearing the international symbol of accessibility?
5.				Is a sign indicating van accessibility mounted at each van-accessible parking space?

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6.				Is at least one passenger loading zone accessible?
7.				Is the pedestrian aisle parallel to where vehicles pull up?
8.				Is the pedestrian aisle at least 5 feet wide and 20 feet long?
9.				Is the pedestrian aisle firm, stable, and slip resistant?
				Outdoor Access—Pathways *(ADAAG 4.3)*
10.				Is at least one path of travel free of steps and stairs?
11.				Is the path of travel firm, stable, and slip resistant?
12.				Is the pathway at least 36 inches wide?
13.				Are all doors and gates along the pathway at least 36 inches wide?
				Outdoor Access—Protruding Objects *(ADAAG 4.4)*
14.				Is there a minimum of 80 inches of headroom along the path of travel
15.				Are objects in the path of travel that protrude more than 4 inches and are 27 inches or more above the floor marked by some detectable means at a lower level?
16.				Is there a pathway at least 36 inches wide around protruding obstructions?
				Outdoor Access—Curb Cuts *(ADAAG 4.7)*
17.				Are curb cuts located where they are needed?
18.				Is each curb cut at least 36 inches wide?
19.				Is the slope ratio of each curb cut no greater than 1:12?
20.				Is the slope ratio of each of the flared sides of each curb cut no greater than 1:10?

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21.				If built-up curb ramps are used instead of curb cuts, do they avoid interfering with vehicular traffic?
22.				Are curb cut/ramp surfaces firm and slip resistant?
				Outdoor Access—Ramps *(ADAAG 4.8)*
23.				Is the slope ratio of each ramp no greater than 1:12?
24.				If a ramp rises more than 30 inches, are there 5-foot-long level landing areas positioned so that the ramp does not rise more than 30 inches between landings?
25.				Are all ramps at least 36 inches wide?
26.				Do all ramps that rise higher than 6 inches have hand rails on both sides?
27.				Are there at least 36 inches between the hand railings?
				Outdoor Access—Entrances *(ADAAG 4.13, 14.14)*
28.				If the main entrance has steps, is there an alternative accessible route that a person in a wheelchair can negotiate independently?
29.				Is there adequate signage directing individuals to the nearest accessible entrance?
30.				Does the doorway of the accessible entrance have at least a 32-inch clearance when open? Or, if the entrance has double doors, does at least one door leaf have a 32-inch clearance?
31.				If there are two doors in series, do the doors swing in the same direction?
32.				If there are two doors in series, are there at least 48 inches plus the width of one door between the two doors?

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33.				Is there a minimum of 18 inches of clearance beside the latch side of the door to give an individual in a wheelchair the space to maneuver around the door when opening it? Or does the door have an automatic opener?
34.				Is the floor or ground area in front of the doorway clear and level?
35.				Is the threshold relatively level with the floor on either side (1/4 inch or less high)?
36.				If the threshold is between ¼ and ½ inch high, is it beveled?
37.				Ifs the door handle easy to operate with one hand and no higher than 48 inches above the floor? (try opening the door with a closed fist.)
38.				Can interior doors be opened with 5 pounds or less of pressure? (A fish scale can be used to measure the force required.)
39.				If the door has a closer, does it take at least 3 seconds to close?
				Building Access—Horizontal (ADAAG 4.3, 14.13)
40.				Is there an accessible link between the main floor, the lobby or elevator, and the accessible entrance?
41.				Is the accessible route at least 36 inches wide?
42.				Are there areas where an individual in a wheelchair can change direction? (Typically, this requires a T-shaped space or a space 60 inches in diameter.)
43.				Do all doorways along the accessible route have a minimum of 32 inches of clearance?
44.				Is there at least 18 inches of clearance beside the latch side of all door s to give an individual in a wheelchair room to maneuver around each door?

45.				Are all thresholds relatively level with the floor on each side (1/4 inch or less high)?
46.				If any threshold is between ¼ and ½ inches high, is it beveled?
47.				Is the door handle easy to operate with one hand and no higher than 48 inches above the floor?
48.				Can interior doors be opened with 5 pounds or less of pressure?
				Building Access—Ramps, Lifts, Stairs, and Elevators *(ADAAG 4.8, 4.9, 4.10, 4.11)*
49.				Are there ramps, lifts, or elevators to all levels where services are provided to the public?
50.				Are ramp slope ratios no greater than 1:12?
51.				Can lifts be operated independently?
52.				If not, is there a mechanism to call for assistance?
53.				Is there at least a 30-by-48-inch clear space in front of each lift?
54.				If a forward reach is required, are the lift controls no higher than 48 inches?
55.				If a side reach is required, are the controls no higher than 54 inches?
56.				Is the lift platform at least 30 inches wide by 48 inches long?
57.				Are elevator call buttons no higher than 42 inches above the floor?
58.				Are there raised and Braille floor designations on both sides of the elevator door at a height of 60 inches above the floor?

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59.				Is the control panel in the elevator car no higher than 54 inches above the floor for a side approach or 48 inches above the floor for a frontal approach?
60.				Are the control buttons in the elevator car identified with both Braille and raised characters?
61.				Do the elevator doors remain fully open for a minimum of 3 seconds?
62.				If an emergency two-way communication system is provided inside the elevator, is it operable without voice communication?
63.				Do stair treads have a nonslip surface?
64.				Is there a continuous handrail on each side of the stairs that extends at least 12 inches beyond the top and bottom steps?
				Building Access—Public Rooms and Spaces *(ADAAG 4.2, 4.4, 4.5, 4.30)*
65.				Are all corridors, aisles, and pathways that lead to areas where goods and services are provided at least 36 inches wide?
66.				Is carpeting securely attached at the edges?
67.				Does the carpeting have a low pile?
68.				Is there a minimum of 80 inches of headroom along all routes leading to public areas?
69.				Are objects in the path of travel that protrude more than 4 inches and are 27 inches or more above the floor marked by some detectable means at a lower level?
70.				Is there sufficient space (60 inches in diameter or a T-shaped space) to allow an individual in a wheelchair to change direction?

71.				Do signs adequately describe permanent rooms and spaces such as bathrooms and exits? (Signs should use raised and Braille characters to identify permanent rooms and spaces and to indicate room numbers. Each sign should have good contrast and be mounted 60 inches high adjacent to the latch side of the door.)
				Seats, Tables, and Counters *(ADAAG 4.2, 4.32)*
72.				Is there 36 inches of clearance between all pieces of furniture, including tables and chairs?
73.				If fixed or built-in seats or tables are provided, is a sufficient number accessible to persons using wheelchairs?
74.				Is there sufficient space for wheelchair seating?
75.				Is there adequate space under tables for a person using a wheelchair to use them? (At least 27 inches from the bottom of a table to the floor, 30 inches wide, and 19 inches deep.)
76.				Are table or counter tops 28-34 inches high?
				Public Restrooms *(ADAAG 4.1, 4.2, 4.13, 4.16, 4.17, 4.19, 4.22, 4.27)*
77.				Is at least one public restroom fully accessible?
78.				Are signs posted at inaccessible restrooms and throughout the building to direct individuals to an accessible restroom?
79.				Are all doorways at least 32 inches wide?
80.				Are door handles easy to operate with one hand and no higher than 48 inches above the floor?
81.				Can the doors be opened with 5 pounds or less of pressure?

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82.				Is the door swing outside the floor space used to access restroom fixtures?
83.				Is there at least one accessible toilet between 17 and 19 inches high?
84.				Is there an unobstructed 36-inch-wide path to all restroom fixtures?
85.				Is there an unobstructed turning space of at least 60 inches in diameter inside the restroom?
86.				Are grab bars mounted both behind the toilet and on the side wall closest to the toilet?
87.				Are the grab bars mounted between 33 and 36 inches high, with exactly 1-1/2 inches of clearance between the wall and each grab bar?
88.				If toilet stalls are used, is at least one stall wheelchair accessible?
89.				Is the accessible stall door 32 inches wide?
90.				Can the stall door be opened easily with one hand?
91.				Does the accessible stall door swing away from the stall?
92.				Does the accessible stall provide a clear floor space of at least 60 inches in diameter?
				Wash Basins and Mirrors
93.				Is there clear floor space of at least 30 inches by 48 inches in front of the wash basin?
94.				Is the wash basin rim or countertop no higher than 34 inches?
95.				Is there at least 29 inches of clearance between the floor and the bottom of the wash basin?
96.				Are the hot water and drain pipes insulated or covered to prevent burns?

97.				Can the faucet be operated easily with one hand?
98.				If the faucet valve is self-closing, does it remain open for at least 10 seconds?
99.				Is there at least one mirror mounted so that the bottom edge of the reflecting surface is no higher than 40 inches?
100.				Does at least one wash basin meet all the preceding requirements?
				Dispensers
101.				Is at least one of each type of dispenser accessible?
102.				Are accessible dispensers on an accessible route?
103.				If a forward reach is required, is the highest operable part of each dispenser no higher than 48 inches?
104.				If a side reach is possible, is the highest operable part no higher than 54 inches?
105.				Can the dispenser be operated with only one hand?
				Drinking Fountains *(ADAAG 4.15)*
106.				Does at least one drinking fountain have a clear space alongside it that is at least 30 by 48 inches?
107.				Are there 27 inches of clearance between the bottom of the unit and the floor to allow an individual in a wheelchair to roll under it?
108.				Can the controls be operated without tight grasping, pinching, or twisting of the wrist?

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				Public Telephones *(ADAAG 4.31)*
109.				If public telephones are available, is there a clear floor space of at least 30 inches by 48 inches in front of one phone in each phone bank?
110.				If a forward approach is necessary, is the highest operable part of the accessible telephone no higher than 48 inches?
111.				Is the highest operable part of the telephone no higher than 54 inches, so that an individual in a wheelchair can access the telephone from the side?
112.				If the public telephones protrude more than 4 inches into the path of travel, is it identified for safety?
113.				Does the accessible telephone have push-button controls?
114.				Is the cord to the accessible telephone at least 29 inches long?
115.				Is the accessible telephone hearing-aid compatible?
116.				Is the accessible telephone equipped with a volume control?
117.				Is the accessible telephone equipped with a TDD, or does it accept portable TDDs?
118.				If a telephone book is provided, is it within the reach of an individual in a wheelchair?
119.				Is there signage to direct individuals to the accessible telephone?
				Emergency Egress/Alarms *(ADAAG 4.28)*
120.				Are there accessible pathways for emergency egress?
121.				Are accessible egress pathways well lighted?
122.				Are fire alarms both visible and audible?

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APPENDIX II

FOCUS GROUP DISCUSSION GUIDE

DISABILITY GROUPS ONLY

1. Is there a place in your community where people are able to visit to talk and seek services about relationships, sex, contraception, sexually transmitted infections, HIV/AIDS, family planning and antenatal care services?
2. What difficulties do persons with disabilities encounter in a bid to access sexual and reproductive health services at service delivery points? **[Difficulties to be looked at in terms of disability types namely : physically challenged, hearing & speech impaired, visually impaired and mentally handicapped]** (Are health facilities physically structured to support people with disabilities?).
3. Apart from the challenges at the service delivery points, what other barriers restrict persons with disabilities from accessing sexual and reproductive health services in your locality?
4. In your opinion, what do you think can be done to improve sexual and reproductive service delivery for persons with disabilities?

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APPENDIX III

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SCHOOL OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF ALLIED HEALTH SCIENCES

Challenges in Accessing Sexual and Reproductive Health Services by Persons with Disabilities

Questionnaire for Health Service Providers

Informed Consent

We are conducting a study on the challenges confronting persons with disabilities in accessing sexual and reproductive health services. We would very much appreciate your participation in this study. The study is an academic exercise and whatever information you provide will be kept strictly confidential.

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Date: ---

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INTERVIEW GUIDE FOR SERVICE PROVIDERS

1. Name of Health Facility ---
2. Location:--
3. Year of Establishment --
4. Is the Facility Registered or Licensed? -------------------------------------
5. Type of health facility / service (Circle one that is applicable : Government / Private
6. Enumerate Any Sexual and Reproductive Health (SRH) services rendered by the health

   Facility/ service provider. --

   ----
7. Do persons with Disabilities patronize your services? (Circle one that is applicable) Yes / No
8. How many persons with disabilities came to seek your services within the last 12 months?

   M ( ) F ( ) T [ ]: Thereon; Physically Challenged ( ) visually impaired ( )

   Hearing / Speech impaired ( ) Mentally Challenged ( ) others ( ).
9. Do you have any difficulties dealing with persons with disabilities seeking your services? (circle one that is applicable) Yes/ No

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10. What specific difficulties do you have dealing with the following categories of persons with disabilities seeking your services?

A. The Physically Challenged ---

B. The Visually impaired ---

C. The Hearing / Speech impaired --

D. The mentally challenged --

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11. Suggest any ways by which your services can be made more inclusive for persons with disabilities.--

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Thank You.

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APPENDIX IV

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SCHOOL OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF ALLIED HEALTH SCIENCES

UNIVERSITY FOR DEVELOPMENT STUDIES

Challenges in Accessing Sexual and Reproductive Health Services by Persons with Disabilities

Questionnaire for Persons with Disabilities Exiting from Health Facilities

Informed Consent

We are conducting a study on the challenges confronting persons with disabilities in accessing sexual and reproductive health services. We would very much appreciate your participation in this study. The interview will last between 30- 45 minutes. Whatever information you provide will be kept strictly confidential.

It is voluntary to participate in the study and if for any reason you don't want to answer any question, please, let us know, we will go to the next question. Also, you are at liberty to stop this interview any time you wish and in such cases don't hesitate to let us know. However, your views are extremely important and your full participation will be very much appreciated. Do you have any question for clarification on the study? May we start the interview now?

Date: --

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SOCIO-DEMOGRAPHIC DATA

1. How old are you? -----------------------------
2. Sex A. Male B. Female
3. Disability, A .Physical B. Visual C. Hearing D. Mental E. None
4. Marital Status, A. married B. single C. cohabiting D. divorced E. widowed
5. Educational Level, A. None B. Basic C. Secondary D. Technical/Vocational e.Tertiary
6. Employment Status, A. Student B. Unemployed C. Self-employed D. gainfully employed
7. How old were you when you started working for pay? -----------------
8. Are you currently working pay? A. yes B. No
9. What type of work did/are you engage in?----------------------------------
10. Religion A. Islam B. Christianity C. Traditional D. Other , Specify -------------
11. Do you live with your parents?
12. Which of the following people do you find it easier discussing sex-related issues with?

    A. Father B. Mother .C Sisters. E. Brothers F. Friends

KNOWLEDGE ON REPRODUCTIVE HEALTH

13. Is there a place in your community where people like you are able to visit to talkand find out about relationships, sex, contraception, sexually transmitted infections, HIV/AIDS, etc?

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14. Where did you learn about the changes in body during teenage years? A. Family B. Friends C. School D. Doctors E. Books/magazines F. Other Specify -----------
15. From whom or where would you prefer to have received more information on SRH issues?

    A. School B. Family C. Friends D. Doctors E. Books/Magazines F. Other Specify --------
16. Have you ever had the opportunity to discuss relationship between boys and girls A.Yes B No
17. If yes, where did you have the discussion? A. School B. Church C.Youth Centre D. Internet Café

KNOWLEDGE ON SEX, STIs AND REPRODUCTION

18. Can a girl become pregnant on the very first time that she has sexual intercourse? A. Yes B. No C. Don't Know
19. Will a girl stop growing after she has had sexual intercourse for the first time? A.Yes B. No C. Don't Know
20. Can a girl become pregnant before starting menstruation? A. Yes B. No C. I don't know
21. Have you ever heard about HIV/AIDs? A. Yes B. No C. I don't know
22. Can HIV infection be prevented? A. Yes B. No C. Don't know
23. Can sharing of food with someone who is infected transmit HIV infection? A .Yes B. No
24. Can HIV be transmitted through the sharing of needles? A. Yes B. No
25. Can HIV be transmitted through blood transfusion? A. Yes B. No

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26. Can being faithful to uninfected partner prevent HIV Infection? A Yes B No
27. Can using a condom when having sex with someone who is HIV infected prevent infection? A.Yes B. No
28. Is it possible for a healthy looking person to have HIV Virus? A. Yes B. No
29. Can people get the HIV virus because of witchcraft or other supernatural means? A. Yes B. No
30. Can HIV be transmitted during delivery, if the mother is HIV Positive? A. Yes B. No
31. What treatments are effective for HIV and AIDS? A. Sex with a virgin B. Antiretroviral drugs C. Herbal Medicine
32. A person can get HIV the first time he/she had sex. A. Yes B.No

33. A child born to HIV positive mother will always be HIV positive. A. Yes B. No C. Don't know
34. HIV /AIDs can be transmitted through physical contact with an infected person? A. Yes B. No C. I don't know
35. Have you ever tested for HIV? A. Yes B. No
36. If yes when did you do the test? A. Less than a month B 2-3 months C. 4-6 months D. Over 6 months
37. If no to question 35, why? A. Afraid to know my status B. Lack of Confidentiality among service providers C.No VCT services available
38. Should people who are HIV positive be allowed to marry? A. Yes B. No C. Don't Know

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39. Which sexually transmitted Infections (STIs) do you know? A. Hapititis B. Syphilis C. HIV/AIDS D. Gonorrhoea E. Chlamydia
40. What are the signs and symptoms of STIs? in men? A. Discharges from penis B. Pain during urination C. Ulcers/ sores in genital area E. .Don't know.
41. What are the signs and symptoms of STIs in women? A. Vaginal discharge B. Pain during urination C. Ulcers/sores in genital area D. Don't know

ATTITUDE TOWARDS PEOPLE LIVING WITH HIV/AIDS

42. If someone in your family is infected with HIV/AIDs, would you look after them and even eat with them? A. Yes B. No
43. Should children whose parents are HIV positive be allowed to mix with other children in School and at play? A. Yes B. No
44. Should people who are HIV Positive be allowed to take part in Church or religious activities? A. Yes B. No
45. Would you like to be taught by a teacher who is HIV positive? A. Yes B. No

46. Would you buy food from a vendor who is HIV/AIDs positive? A. Yes B. No
47. Would you like to sleep in the same room with a relative who is HIV positive A. Yes B. No
48. Do you know of any challenges that persons with disabilities who are HIV positive encounter while accessing HIV AIDs services in your locality? A.Yes B. No

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49. If yes to question 48, enumerate the challenges.--------------------------------------
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50. Suggest any ways of improving HIV/AIDs service delivery for persons with disabilities in your locality--
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KNOWLEDGE ON ABORTION PRACTICES

51. What will you do to an unwanted pregnancy? A. Abort it B. Keep it C. commit suicide D. Others ---

52. If you will abort it by what means will you abort it? A. Go to health service provider B. Report to herbalist C. Self-induced abortion

53. Have you ever aborted a pregnancy? A. Yes B. No

54. Who will you first discuss the issue of unwanted pregnancy with? A. Friends B. Parents C. Health officer in government health facility D. Health officer in a private health facility E. Religious leader F. Teacher. G. Brother H. Sister

55. Apart from the health facility, are there places or people who do abortion in your community? A. Yes B. No C. Don’t know

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56. What materials do people use to conduct abortion in your community? ------------

57. Is it difficult to get someone to do abortion in your community? A. Yes B. No C. Don't know

58. Do persons with disabilities encounter any difficulties in accessing abortion services in your locality? A. Yes B. No

59. If yes to question 56, what practical difficulties do they encounter? -----------------
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60. Suggest any ways of improving abortion services for persons with disabilities in your locality? ---
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KNOWLEDGE ON FAMILY PLANNING AND CONTRACEPTION

61. Have you heard about family planning before? A. Yes B. No

62. If yes to question 55 where? A. School B. Market C. Health facility D. Friends E. Church/Mosque F. Mass Media G. Other ------------------------------------.

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63. Which of the following contraceptives and family planning service do you know? A. Pill B. Emergency Contraception C. Male Condom D. Female Condom E. IUD F. Injectable/ Depo-provera /Norigynon G. Diaphragm/foam tablets/jelly/cream H. Norplant I. Male sterilization J. Female Sterilization K. Withdrawal L. Calendar Method
64. Do you know where to get condom? A. Yes B. No
65. Do you know where to get pill or injection? A. Yes B. No
66. If a friend of yours needs treatment for a sexually transmitted disease, where could he/she obtain such treatment? A. Shop B. Pharmacy C. Health Facility D. Youth Corner E. Traditional Healer F. Other (Specify) --------------------------------
67. Where will you go for support when you have sexual health problems? A. Health Facility B. Herbalist C. Youth Corner D. Faith based healer
68. Where will you prefer to give birth when pregnant? A. At home B. Health Facility C. TBA C. Faith Based Healing Centre
69. Would it be too embarrassing to obtain or buy condoms? A. Yes D.No
70. Have you ever used contraceptive method? A. Yes B. No
71. What contraceptive method do you mostly use? A. Male condoms B. Female Condoms C. Pill D. IUD E. Other (Specify) --
72. Where do you get your preferred contraceptive method? A. Shop B. Pharmacy C. Health Facility D. Other (Specify) ---
73. Are there any challenges in accessing your preferred contraceptive method? A. Yes B. No

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74. If yes to question 63, enumerate the challenges often encountered, ------------------

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75. Do you know of any other challenges that persons with disabilities encounter while accessing family planning /contraceptive services in your place? A. Yes B. No

76. If yes to question 71, list the challenges ---

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77. In your opinion, what can be done to improve family planning/contraceptive services for persons with disabilities in your community? ----------------------------

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PERCEPTION AND UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

78. Have you ever visited a health facility or a service provider of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted diseases? A. Yes B. No

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79. How many times have you sought services or information from a service provider for these services within the last 12 months? -------------------------------

80. Thinking about your last visit, where did you go? A. Government health facility B.

    Private health provider C. Youth Corner D. Other (Specify) -------------------------

81. What necessitated your last visit to the health facility or provider?

    A. For treatment of minor ailment B. For information C. Abortion D. Family Planning E. Other (Specify) ------------------------------

82. At the service delivery point that you last visited, did you see posters on contraception? A. Yes B. No

83. Were you given brochures on contraception? A. Yes B. No

84. Did you feel comfortable enough to ask questions A. Yes B. No

85. Were the questions you asked during the visit adequately answered? A. Yes B. No

86. Was there enough confidentiality? A. Yes B. No

87. Was the health facility or services rendered user-friendly to persons with disabilities? A. Yes B. No

88. If yes to question 87, what made the facility or the service disability inclusive? ---

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89. If No to question 87, why --

ANTENATAL CARE FOR PERSONS WITH DISABILITIES DURING PREGNANCY

90. Did you plan for your present pregnancy? A. Yes B. No
91. How many months was your pregnancy when you first received antenatal services? -------
92. How many times did you receive ANC services during the last pregnancy? --------
93. Who makes the decision for you to seek prenatal care? A. Husband B. Mother in-law C. Friends D. Self E. Other (Specify) ----------------------------
94. Are you registered under the National Health Insurance Scheme? A. Yes B. No
95. Are ANC services disability inclusive in your locality? A. Yes B. No
96. If yes to question 95, what makes it disability inclusive or friendly? -----------------

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97. If No to question 95 , why ---

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98. Suggest any ways of improving ANC services for persons with disabilities in your locality. ---

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99. Select any one of the following as your preferred choice of delivery A. Home delivery by a TBA B. Skilled delivery at health facility by a midwife.

Give reasons for your choice in question 99? ---
