UNIVERSITY FOR DEVELOPMENT STUDIES

THE EXPERIENCES OF WOMEN WITH DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES IN BOLGATANGA MUNICIPALITY

BY

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DECLARATION

Student Declaration

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

Candidate's Signature: .... Date: 28/09/21

....

Name: Gnansin Mathias Nampar

Supervisor's Declaration

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

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ABSTRACT

People living with disabilities are individuals in society who are faced with challenges in performing normal daily activities of living due to physical or mental malfunction**.** It is estimated that the world's population is made up of 15% of persons with disabilities with a great majority from low-income countries especially in Africa.

These individuals living with disabilities require quality health care including the area of reproduction by the state. After a decade of the enactment of Persons with Disability Act of Ghana (Act 715), Persons with Disabilities (PWDs) seem not to have seen significant changes in their wellbeing, particularly meeting their reproductive health needs. Some Ghanaians believe that PWDs have no needs for sexual and reproductive services. The health care system, society and various governments have failed to show enough commitment to uphold policies that enhance access to Sexual Reproductive Health (SRH) services by Women with Disabilities (WWDs). This study explored the experiences women with disabilities face in accessing reproductive health services. The main objective of the study was to explore the experiences of WWDs in accessing reproductive health services in Bolgatanga Municipality. Qualitative method was used to collect data from WWDs aged 15 - 49 years. The respondents were stratified to include the various forms of disabilities (physical, visual, and speech and hearing impaired persons) and purposively selected a total of 24 respondents.

The Braun and Clarke (2006) framework for thematic analysis was used to analyse data. Findings revealed unfriendly infrastructure for persons with disabilities at health facilities, unfriendly attitudes of some health personnel and other clients towards WWDs, inadequate support from family members and society, and communication barriers during reproductive health care seeking. The government with partnership of other stakeholders should be committed and promote policies that facilitate access to sexual and reproductive services to women with disabilities.

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DEDICATION

This work is dedicated to my family for their unwavering support.

TABLE OF CONTENT

Contents

page

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS/ACRONYMS

ANC:	Antenatal Care
CHNs:	Community Health Nurses
GSS:	Ghana Statistical Service
FGDs:	Focus Group Discussion
FP:	Family Planning
HeFRA:	Health Facility Regulatory Agency
HIV/AIDS:	Human Immune Virus /Acquire Immune Deficiency Syndrome
ICPD PoA:	International Conference on Population and Development Programme of Action
MOH:	Ministry of Health
NGOs:	Non-Governmental Organisations
NHIS:	National Health Insurance Scheme
PA:	Physician Assistant
PNC:	Postnatal Care
PWD:	Person with Disability
PWDs:	Person with Disabilities
PWPDs:	Persons with Physical Disabilities
RHS:	Reproductive Health Service
SRH:	Sexual and Reproductive Health
STI:	Sexually Transmitted Infection
UN:	United Nation
UNFPA:	Nations Fund for Population Activities
WB:	World Bank
WHO:	World Health Organisation
WWDs:	Women with Disabilities
WWPDs:	Women with Physical Disabilities

OPERATIONAL DEFINITION OF TERMS

Able persons: individuals without any form of structural or functional defect and has ability to perform normal activities of a human being.

Access: one's ability to gain entry, admission, or right to use the facilities and obtain the services and commodities.

Antenatal care: the routine health care service given to pregnant women that include weighing to know the progress of the pregnancy, screening for some diseases, health education on early detection and reporting of danger signs of pregnancy, healthy lifestyle, and preparation towards delivery.

Disability: any form of structural and functional defect that restricts one's ability to perform activity within a range considered normal for human being.

Family planning: the deliberate practice of controlling childbirth by means of using contraceptive drugs, device, or surgical intervention.

Impairment: any physical or functional loss of anatomical structure of a person which is either temporal or permanent.

Postnatal care: the health care given to mother and her new-born baby shortly after birth till six weeks of life.

Reproductive health service: a state of complete physical, mental, and social well-being of an individual and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions

CHAPTER ONE

INTRODUCTION

1.0 Overview

This chapter looked at the background of the study, statement of problem, justification of the study, research questions, objectives of the study, relevance of the study, scope of the study, conceptual framework, and structure of the thesis.

1.1 Background of the Study

People living with disabilities are individuals in society who are faced with challenges in performing normal daily activities of living due to physical or mental malfunction as a result of ill health or injuries they suffered or born with**.** Smeltzer *et al.*, (2010) described a person to have a disability when such individuals have limitation in performance or function in everyday activities, (difficulty talking, hearing, seeing, walking, climbing stairs, lifting or carrying objects, working at a job). United Nations (UN) convention on Right of Persons with Disabilities (2006: p4), identified people with disabilities as "those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". Also, Ghana Statistical Service (GSS) (2012: p Xiii) defined disability as 'those who were unable to or were restricted in the performance of specific tasks/activities due to loss of function of some part of the body as a result of impairment or malformation''. These disabilities include visual/sight impairment, hearing impairment, speech impairment, physical disability, intellectual disability, and emotional or behavioural disorders. Persons with disabilities (PWD) constitute a large portion of the population in the world who contribute in diverse ways to the growth of society. According to the UN (2007), approximately one in every 10 persons, totalling 650 million people live with disability worldwide. WHO and World Bank (2011) also states that the world's population is made up of 15% of persons with disabilities. Persons with disabilities are found in all age groups and both sexes.

Disability can develop due to several factors including complications from disease conditions. In Africa, where morbidity of communicable and non-communicable diseases is common, complications from these diseases in the form of deformities are most likely to occur. Studies show that a great majority of PWDs are in low-income countries especially in Africa (United Nations (UN) 2007). It is estimated that globally, 80% of the population with disability live in low-income countries including Ghana. Research shows that about 737,743 of Ghana's population (3% of the population) are PWDs (GSS, 2012). Other findings estimate Ghana's disability rate to be between 7–12%, approximately 1.55–2.2 million people (WHO and the Word Bank, 2011). In 2010 population census, Upper East Region's disabilities data revealed 14.1% physically challenged,11.8% hearing impaired, 5.4% speech impaired and 30.9% visually impaired (GSS, 2012).

Individuals living with disabilities require quality health care including the area of reproduction. The UN (2006), Article 9 of the convention demands for better accessibility for persons with disabilities including access to medical facilities and information. Women with disability (WWDs) are guaranteed the right to ‘‘the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including the area of sexual and reproductive health and population-based public health programmes’’ (UN, 2006). The Convention mandates the states to ensure these people enjoy equal access to health services, with emphasis on sexual and reproductive health and public health programmes.

Ghana passed the Persons with Disability Act (Act 715) in 2006 to address the needs of these persons. Although the act seems not to have full implementation and enforcement, it provides PWDs the right to access the same or specialized sort, and quality of health care as offered to able persons, in addition to sexual and reproductive health services (Persons with Disability Act of Ghana, Act 715, 2006). Interestingly, over ten years of enactment of Persons with Disability Act of Ghana (Act 715), PWD seem not to have seen significant changes in their wellbeing including meeting their reproductive health needs. This is because many people still believe that PWDs have no needs for sexual and reproductive services because they are sexually unattractive and inactive **(**Potgieter and Khan, 2005). According to Yale University and World Bank (2004), PWDs are equally active sexually just like other people without disabilities and therefore require the same Sexual and Reproductive Health (SRH) needs. Based on their vulnerability to abuse, PWDs may have more demand for SRH education and care than able persons (WHO, 2009).

Evidence shows that persons with disability are more exposed to abuses including sexual abuse **(**Mavuso and Maharaj, 2015)**.** Lancet (2012) concluded that, PWDs are at high risk of experiencing physical, psychological, and sexual abuse among other gender-based violence. This predisposes them to HIV/AIDS and other sexually transmitted infections. Unfortunately, they are often faced with obstacles to SRH information and services probably due to ignorance and attitudes of society towards them, including health care professionals.

In the developing countries where poverty rate is high, it is less likely that PWDs needs are met including health services (WHO and World Bank, 2011). These people are not equally spared stigma and denial of access to health services, education, and employment, among others due to their disability. They are often overlooked or neglected by society. In the past and even today in some communities in Ghana, societal beliefs around some disabilities result in negative implications for their wellbeing. For example, giving birth to a child with a deformity or disability, is believed to be caused by either evil spirits or punishment from gods to the family for failing to keep taboos (Awedoba and Denham, 2013). According to them, in such instances, in some communities, infanticide is carried out or the child is ostracised. Many people in our society today still perceive persons with disabilities as ‘‘bad luck people’’. It is a common belief in some northern ethnic groups that if you see a visually impaired person (normally those with “one eye”) early in the morning before you take breakfast, your day is going to be full of bad luck. As a result of some of these perceptions, some PWDs have been denied relationship and marriage. UNFPA (2007) revealed that persons with disability have been pushed to undergo sterilizations, abortions, or forced marriages in the past. These people have also been deprived of information regarding sexual and reproductive health. Indeed, today nothing significant has changed with regard to giving them the needed respect in society, freedom of right to enjoy what others benefit including good health care more particularly SRH services. Article 23 of the UN (2007) requires that all States should get rid of discrimination against PWDs in all issues regarding relationship, marriage, and childbearing not excluding issues of family planning and fertility. These rights enshrined in Persons with Disability Act of Ghana (Act 715), seem not to adequately serve the intended purpose as disabled persons do not easily access or enjoy SRH services in Upper East Region with ease.

1.2 Statement of Problem

Women with disabilities (WWDs) have numerous needs including that of health. These health needs do not exclude their SRH needs just like any other woman who is not disabled. As cited in WHO (2009), International Conference on Population and Development Programme of Action (ICPD PoA) recognized that, it is ‘the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health’’. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in the human rights documents (Glasier *et al*., 2006).

These very important rights seem not to be enjoyed by people living with disabilities in developing countries like Ghana. The health care system, society and various governments have failed to show enough commitment to uphold policies that enhance access to Reproductive Health Services (RHS) by WWDs. While a number of studies (Ayaga *et al.*, 1999; Yakong *et al.*, 2010; Ganle *et al.*,2016), have assessed the factors that influence accessibility and utilization of RHS by able people, there is little evidence about disabled women’s access to SRH needs/services in Ghana. The above studies suggest that even able persons face challenges accessing the needed RHS to improve maternal health for a number of reasons. This means that the challenges could even be more for women living with disabilities when accessing care, yet there are limited studies focusing on this category of women in Ghana. This study therefore explored the experiences of women with disabilities in accessing reproductive health services in Bolgatanga municipality.

1.3 Research Questions

1. What are the factors that influence access to RHS by women with disability (WWD) in Bolgatanga Municipality?

2. What reception do women with disability get from other clients and health care providers when accessing RHS in Bolgatanga Municipality?
3. Do WWD get health education from health care providers at the reproductive health facilities?
4. What perception do WWD hold on what the society feels about them when accessing RHS?

1.4 Objectives of the Study

1.4.1General Objective

To explore the experiences of women with disabilities in accessing reproductive health services in Bolgatanga Municipality.

1.4.2 Specific Objectives

1. To assess the factors influencing access to RHS by women with disabilities (WWDs).

2. To explore the attitudes of health care providers and other clients towards WWDs when seeking RHS.

3. To identify the health education/ information WWDs receive regarding RHS.

4. To explore the perception of WWDs on society’s attitudes towards them in accessing reproductive health services.

1.5 Significance of the Study

This study was carried out to fill in the gaps for the improvement of quality health care services in the Bolgatanga Municipality and for policy design to meet the needs of WWDs in Ghana.

The findings of this study will help the Municipal Health Management Team to improve on reproductive health needs of women living with disability in Bolgatanga

Municipality. Recommendation based on the findings shall be provided to decision makers to enable them to formulate better policies and planning towards addressing the reproductive health needs of these women. The results would also go a long way to improving the health needs of WWDs in Bolgatanga Municipality and Ghana as a whole. Besides, it will help address the discrimination challenges these women face to help achieve sustainable development goal three (3) which seeks to address inequalities and build good health for all. It will also serve as basis for future research in this area.

1.6 Delimitation

This study was centred on experiences of WWDs at the time of accessing RHS. Individuals with physical, visual, hearing, and speech impairment within Bolgatanga Municipality were the participants. Women with intellectual disabilities were excluded from the study due to the complexity involved in assessing mental disability coupled with researcher's limited knowledge in undertaking such assessment.

1.7 Structure of the thesis

This work is organized into six (6) chapters. Chapter one (1) deals with the study background on issues of disabilities and access to reproductive health, statement of the problem, research objectives and questions, relevance of the study, delimitation, conceptual framework that underpin the study, and structure of the study.

Chapter two (2) entails the literature review on research work that relates to disability and reproductive health services. It deals with WWDs access to reproductive health services, stigma and discriminations, attitudes of health workers and other clients, health education, communication and information, and health providers skills in handling WWDs during RHS.

Chapter three (3) described the methodology employed for the study. These included study design, study setting, study population, sample size determination, sampling techniques used, data collection instruments and procedure, pretesting, ethical considerations, and analytical framework.

Chapter four (4) focuses on data analysis and presentation.

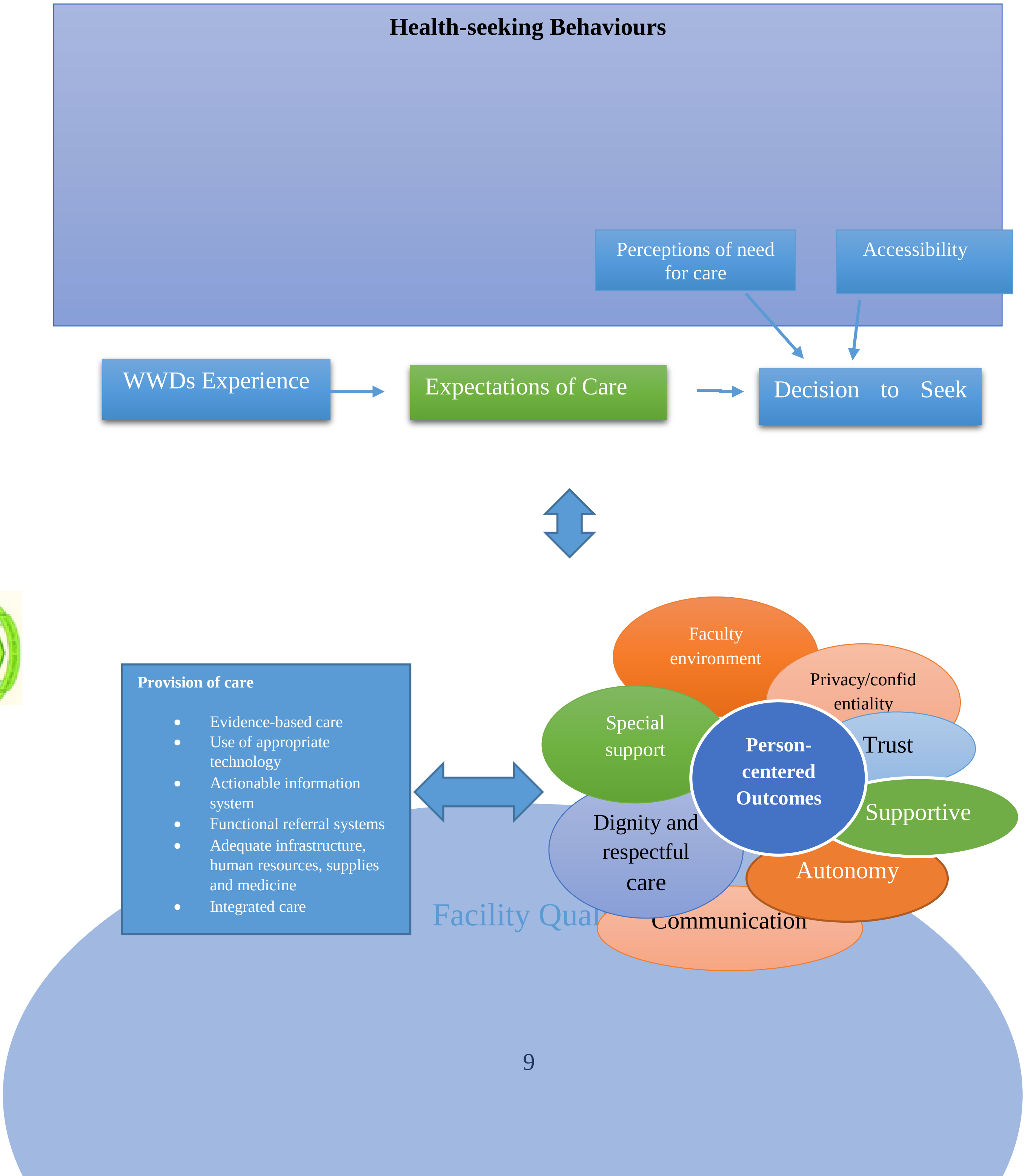
Chapter five (5) deals with the discussion of study findings whilst chapter six (6) focuses on the synopsis of the main findings, conclusions and recommendations geared towards improving reproductive health services access to WWDs.

1.8 Conceptual Framework

Women with disabilities Determinants of reproductive Health quality

Health systems, stigma and discrimination, health education, religion, finance, physical access, time, care providers/other clients' attitude.

Figure 1: conceptual framework



Adapted from Sudhinaraset *et al*., (2017)

The study first and foremost draws its theoretical foundation from person-Centered care approach. The framework above **(**fig1) is adapted from Sudhinaraset *et al*., (2017) person-Centered Care for Reproductive Health Equity that has three levels. These are: societal and community determinants of health equity; women's health-seeking behaviours; and facility-level factors that include provision of technical care and the person-centered dimensions of care.

Secondly, considering WHO's quality of care framework, Tunçalp *et al.*, (2015), it also assumes that there is a two-way directional relationship between provision of care and person-Centered care.

As adapted from the Institute of Medicine, Sudhinaraset *et al.*, (2017) define person-centered reproductive health care as: "Providing of reproductive health care that is respectful of and responsive to individual women and their families' preferences, needs and values, and ensuring that their values guide all clinical decisions" (p3).

From fig 1, the first level entails determinants of health quality which include broader health systems, physical access, finance, time, stigma and discrimination, social status, health education, and care providers and other clients' attitudes.

These determinants of health quality influence health seeking behaviours and the quality of care women experience in the facilities. There is an assumption that the decision to seek care influence women's experiences in the facility, and the quality of care in the facility can also influence their perceptions of care, needs for care, expectations of care, and eventually seeking care. When women or their accompanying relations experiences disrespectful and abusive treatment at health facilities, it is likely to influence future decisions as to whether to use the facility or not or recommend to others to use (Kruk *et al.,* 2009).

The third level is quality care which involves the person-centered care including the following domains: Health facility environment, Respect, Dignity, Trust, Autonomy, Supportive care, Privacy and confidentiality, and Communication.

According to Ronald *et al.,* (2010), these domains are very important in providing the right care for the right person at the right time. Patient-centered care is not disease-centered, technology-centered, physician-centered, or hospital-centered care. However, it ensures that the needs of patients and clients' access to health care services are duly met with respect and responsiveness (Institute of Medicine, 2005). Also, Ronald (2010) described patient-centered as an approach that promote patients and care providers interactions which facilitate two-way flow of information; discover the values of the patients and their preferences; support patients and their families to make clinical decisions; enhance access to appropriate care; and empower patients to modify lifestyle behaviours needed to improve health. Person-Centered Care focuses on the need to respect clients' preferences and values, their physical, psychological and physiological comfort, the need for good communication and support and coordinate care of patient and his/her family (The Picker Institute, 1993; Institute of Medicine, 2005, and Jo-Delaney, 2018). One key advantage of this approach is its focus on promoting patient satisfaction in health care services (Jo-Delaney, 2018). The person -centered care practices in primary health care has also achieved significant benefits for clients, as they gain autonomy and manage their health better when they are well informed and supported (Jo-Delaney, 2018). As a result of its flexibility and focus meeting individualized needs of patients and clients, it has become the standard measure of the quality of care (Australian commission on safety and quality in healthcare (ACSQHC), 2011).

Health communication is an integral part of health care services because care providers need to clearly explain to patients and clients regarding services or their conditions and the purpose of treatments, any side effects of treatments, and verify whether they understand the explanations clearly (Sudhinaraset *et al.,* 2017). Building a continuing discussion can help solve social, psychological, and structural barriers to communication (Coulter, 2002). Communication can be enhanced during service delivery if care providers use non-technical language, frequency smiles and nods, good eye contact, and voice quality (Nicole *et al.*, 2003).

Health facility environment in this person-centered refers to friendliness of the facility to WWDs. The quality of basic amenities is linked to the extent to which the physical infrastructure of a health facility is welcoming and pleasant to WWDs. That is the availability of transportation system within the facility, ramps and grab rails, adequate parking places for people with disabilities; good design of examination rooms, large print and Braille signage; and seats for clients who cannot stand to wait.

Privacy and confidentiality of patient and clients cannot be under rated in health care delivery. This refers to privacy in the environment in which health care services are provided. It also includes confidentiality of communication and the medical records. This is to ensure that others who are not involved in their care do not hear information about their care or see them during physical examinations or during labour and delivery.

Social support in this person - centered domain is viewed as ones feeling of being cared for, loved, and valued by others whom they can depend on should there be the need. The domain looks at the extent to which WWDs gain support from family, friends, other clients and even health care providers when receiving reproductive health care.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter examined existing empirical literature related to experiences of women with disabilities in accessing RHS. This chapter also discussed accessibility to health care, social stigma and discrimination, and time factor. Others included health education/information and communication, attitude of health care provider and other clients, knowledge of health care providers in handling WWDs at health facilities during RHS utilization and perception of women with disability on society's attitude toward them accessing RHS. The key terms used in this study included: women with disabilities, access, and reproductive health. These terms are used in reference to their ordinary meaning or in context.

2.1 Reproductive Health

According to WHO (2006), "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'' (P5). It therefore means that with reproductive health, people will be able to have a gratifying and safe sex life. It also implies that people have the ability to reproduce and the freedom to do so based on their decision as to when and how often. Comprehensive reproductive health care covers: counselling, information, education, communication and clinical services in family planning; safe motherhood; gynaecological care; treatment and prevention of sexually transmitted diseases; prevention and management of sexual violence; and active discouragement of harmful traditional practices such as female genital mutilation (WHO, 2006).

The achievement of Universal Health Coverage which means ensuring access to health services for all, a key objective within the Sustainable Development Goals three (3) will not be met without the inclusion of PWDs. Therefore, to achieve this target, there must be deliberate efforts to include PWDs, as they also make up a large group and may be excluded from the general health and specialist services such as reproductive health care.

Though important, unfortunately, PWDs are often faced with difficulty seeking SRH information and services probably due to ignorance and attitudes of the public and individuals towards them, including healthcare staff. Persons with disabilities needs are often not met including health care services. These people are not equally spared stigma and to the extent that they are sometimes denied access to education, employment, and even health care services among others due to their disability (WHO, 2009). They are also often overlooked or neglected by able persons in society. The social exclusion and neglect of these venerable persons has led to their denial to enjoy what other able persons benefit including quality health care most especially reproductive health care. WHO (2009) support that PWDs get equal variety, quality, and free or affordable health care and public health programmes as it is given to other able persons, not excluding sexual and RHS or programmes.

Persons with disabilities are capable of doing it all if they are given the needed support as it is commonly said ‘disability is not inability’. It is in the light of this that

WHO (2009) revealed that the challenges persons with disabilities face regarding SRH are not necessarily due to the disability, but rather, it reveals lack of social support, legal protection, and understanding by the society. Smeltzer *et al.*, (2010) acknowledged that the health needs of the disabled in health care settings give a lot of difficulties to health staff in respect to how to communicate effectively if there are communication shortfalls, the additional physical demands for mobility, and time needed to offer assistance to client on self-care activities during hospitalization.

The challenges could be centred in the following areas when PWDs are accessing health care service more especially sexual and reproductive health care. These include accessibility, social stigma and discrimination, time factor, information and communication problems, attitudes of health care provider/other clients and skills of health staff in client care.

2.2 Accessibility (Facility, Finance, Services,)

In this work, access refers to one's ability to gain entry, admission, or right to use the facilities. Access is an essential variable in the utilization of health care services to all clients including PWDs. This could be physical accessibility, financial, cultural or services accessibility. The availability, affordability or reliability of this access may have direct or indirect influence in the utilization of the services.

2.2.1 Physical Accessibility

WHO (2011) suggests that to improve access to specialist health service for PWDs, there should be an accessible way to travel from home to health facility, adequate parking places for people with disabilities; good design of examination rooms and clearing hallways of equipment obstructing the path of movement. Others include constructing ramps and grab rails; installing lifts; high contrast, large print and braille signage; providing modified toilets and hand washing facilities; and providing seats for clients who cannot stand to wait. The question left unanswered is, are our health facilities equipped to provide these specialist care. A study by Trani *et al.*, (2011) on health care reproductive health and disability; a large-scale survey in Sierra Leon revealed that PWDs did equally have good access to health facilities including reproductive health practices. Similarly, Mavuso and Maharaj (2015) noted that PWD get access to public health facilities for a variety of RHS that include HIV counselling and testing, STI treatment, and family planning service, among others. However, many studies have reported that access is still a major challenge to disable persons in accessing reproductive health care. Ganle *et al*., (2016) noted in their study that mobility is a problem with women with disability as they could not move from their homes to the health care centres or facilities to receive maternal health care especially those with sight problems, physical disability and those in rural areas. Visual impaired persons will require someone to lead them to health facilities. More often they go with a child who leads the way to the facility. Where there is absence of a child to help, it is not always likely for a community member to assist. Evidence suggests that some community members are not willing to assist persons with disabilities because of fear and stigma (Alister, *et al*., 2017). The challenges are not limited to travelling from home to the health facilities but also within the facilities. Majority of patients with disability particularly the physically challenge and visually impaired persons require assistance because their movement around the health care facilities to access health care services cannot be independent. Absence of this assistance results in dissatisfied service utilization (Alkawai and Alowayyed, 2017).

Similarly, Thomas and Curtis (1997) and WHO (2009) also observed that PWDs are often denied access to SRH services for various explanations that include physical barriers and luck of disability related clinical services.

In a broader perspective, accessibility to health service should not be limited to hospital or clinic but also any other place where one can receive health services. Accessibility should also include areas that health information is given, settings where family planning devices like condoms are sold or distributed and other places that offer SRH services (WHO, 2009).

Means of transport is a main problem for most PWDs especially to those in rural areas where health facilities are far. Many of these people find it difficult to walk to hospitals, clinics, or community centres where SRH services are accessible to source the service. WWDs experience transportation difficulties that include problems getting into or out of a vehicle, drivers refusing to stop for them or to lift the wheelchair into and out of the truck, and long waiting time when using public transport to health facilities (Smeltzer *et al*., 2007).

2.2.2 Financial Access

Women with disabilities often have fewer financial resources than their able peers (Iezzoni *et al*., 2013; and Steinmetz, 2006), and therefore the financial burden of reproductive services may be high for this less privileged population. As a result of their disabilities, they sometimes must seek the services of an assistant, which increases the cost of transportation, and other travel related cost such as feeding. Rugoho and Maphosa (2017) observed that PWDs who rely on personal aid for mobility incur more cost as they pay for two seats on public transport and sometime pay for the wheelchair, which makes it expensive for them to source reproductive health.

Due to high level of poverty among this population, many of them are unable to afford means of transportation that could take them to these centres for services. In the event where there are vehicles with affordable fares, they may not be easily accessible to those with mobility impairments. As a result, PWDs may need to afford their personal mobility equipment like tricycles or prostheses, persons to give assistance, or get financial support to be able to reach ordinary SRH services (WHO and World Bank, 2011). Lack of funds to pay for health care services is most likely to influence low accessibility of health care service by the client especially among persons with disability who generally have low income (Nguyen, *et al.*, 2015; and Rugoho and Maphosa 2017). Ahumuza *et al.,* (2014), and WHO and World Bank (2011) observed that lack of funding and health care insurance creates a barrier to persons living with disabilities to access health care including RHS. Ganle *et al.*, (2016) discovered in their study that cost of maternal health care is not a serious challenge in Ghana because of the free maternal health care policy but the cost involved to get the right means of transport frequently prevent many disabled women from patronizing skilled care. The free maternal services in the public health facilities in Ghana enhance women utilizing the facilities during childbearing. A study by Oredola and Odusanya (2017) observed that patients prefer government facilities because of reduced cost.

Similarly, availability of commodities and other resources such as drugs when provided to client may increase the chances of further demand of the service in future. The same can be observed in the opposite. WHO (2009) affirm that "Accessibility" also implies the availability and provision of resources such as condoms and other commodities to PWDs with the equal rights to privacy, self-determination, and respect that every individual deserves. Mavuso and Maharaj (2015) observed that WWDs would be satisfied with RHS if their needs were met. The lack of adequate care and medication resulted into many PWDs visiting local herbalists (Mulumba *et al.*, 2014).

Availability and friendliness of equipment and aids to support the movement and the discharge of health services to PWDs may also affect the smooth delivery of health care service. Health care settings and equipment with specially design features such as height-adjustable examination tables or availability of a lower bed for examination; seated or platform scales; and wheelchair must be made physically accessible for women with physical disabilities to promote access and utilization (Begley *et al.*, 2010 and WHO and World Bank, 2011). Piotrowski and Snell (2007) affirmed that most of the essential equipment use for adequate patient assessment such as scales, exam tables, and mammography machines are not designed to favour WWD. Even in the places that they are available, they are not friendly.

The availability of appropriate structures at the health facilities to ease WWDs movement into and within the facilities may reduce their challenges. The key challenge that physically disable and visually impaired women face in accessing skilled care at the reproductive care facilities is the unfriendly nature of health care infrastructure as most facilities lack ramps, wheelchairs, well designed delivery beds for PWDs, appropriate separate toilets for disabled persons, and assistants to support the women climb stairs, examination tables and delivery beds (Smeltzer *et al.*, 2010; Ahumuza *et al.*, 2014; and Ganle *et al.*, 2016). It may be a difficult task for WWDs to stand or get well positioned for a mammogram or be transferred to and from an examination table. Inadequate modern equipment such as tables that automatically lower to wheelchair height for easy transfers is a barrier to women with mobility impairments. As a result, in certain instances, care providers resort to physical examination of women while they are still seated in their wheelchairs making the clients feel that they are getting poor-quality care (Iezzoni *et al*., 2010). The small nature of many examination rooms could not accommodate wheelchairs of PWDs and therefore their inability to access the examination table (Stillman *et al*., 2014). Lack of height adjustable examination table coupled with the clinical staff unpreparedness to help safely transfer PWDs to examination table results to denial of client to be examined or weighed.

To ensure that PWDs access quality health care, the client should have access to audible and visual alarm systems, qualified sign language interpreters, large printout of patient education materials and raised lettering and Braille (Mace, 2000).

2.2.3 Social Stigma and Discrimination

PWDs are socially discriminated against due to their physical outlook or their way of life. The stigma on PWDs could be so severe that it makes them isolate themselves from able society. Some community and family members and some health care workers see or treat PWDs as animal and this discriminatory attitude is very much rooted in specific cultures (Mulumba *et al.,* 2014). The WWDs get inadequate support from family member, community members and even the health system during pregnancy and childbirth perhaps due to negative beliefs and perceptions about disability and reproduction (Ganle *et al.,* 2016; and Powell *et al*.,2017).

In the 21st century, many communities in Ghana still belief that if a child is born with a deformity, it is either a cause of evil spirits, or punishment from gods and ancestors to the family for failing to keep taboos (Awedoba and Denham, 2013). In such instances according to them, in some communities, the child is ostracised, or infanticide is carried out. This can be blamed largely on inadequate knowledge regarding disability issues. Inadequate knowledge on disability can result to harmful conjecture among society and even the health care professionals that often lead to stigma against persons with disabilities (Smeltzer *et al*., 2010). This discrimination becomes worse when it comes to their sexual and reproductive life. Many claimed without evidence that persons with disabilities are ‘‘bad luck people’’ and as result do not want to relate with them. In some instances, due to their physical outlook, able persons see them as unattractive and not willing to relate to them sexually. According to Nosek *et al*., (2001); and Mavuso and Maharaj (2015), women with disabilities have limited opportunities to establish intimate or loving relationships. Persons with disabilities have often been denied the right by family members and sometimes community members to begin relationships and to make decisions with regards to when and with whom to have a family (WHO, 2009). UNFPA (2007) study also showed that many others have been pushed to sterilizations, forced abortions, or marriages. WHO (2009) noted that both the disability community has ignored SRH of PWDs and health workers providing SRH care. As a result of this, PWDs are believed to be among the most marginalized groups when it comes to SRH services. It is in the light of this that Article 23 of the U N Convention (2006) requires Nations to abolish discrimination against PWDs in respect to relationships, marriage and parenthood, family planning, fertility, and their family life. Women with disability are guaranteed the right to ‘‘the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes’’ (article 25a, UN, 2006).

The discrimination against PWDs could affect their moral to access reproductive health care. Individuals with disability experienced discrimination that impacted negatively on their ability to access health services and medicines and viewed it as a violation of the right to health, and other human rights breaches by health care workers (Mulumba, 2014). These persons encounter many obstacles to access health care and information about SRH. This is based on the perceptions that persons with disabilities are not sexually active and therefore do not need SRH services. The stigma linked with disability has led to misconception and false believes that PWDs are not sexually active, nonsexual, have no interest in sex, or in capable of participating in sexual activity (Nosek and Simmons, 2007). Though Smeltzer *et al*., (2010) acknowledged that persons with disability may have physical and emotional difficulties that interfere with sexual activities, they have sexual feelings. Many studies have provided evidence that people with disabilities are sexually active like any other person. Regrettably, society and some health personnel contribute to these menaces by ignoring patients' sexual rights and viewing disabled persons as asexual. Study also shows that persons with disabilities are equally sexually active as persons without disabilities (Trani, 2011). It is therefore erroneous for one to assume that PWDs do not need sexual and reproductive services. They equally require the same sexual and reproductive health needs or care just like anyone else. WHO (2009) affirmed that PWDs might actually have greater needs for sexual and reproductive health education and care than others without disabilities due to their vulnerability to abuse.

Gibson and Mykitiuk **(**2012) indicated that PWDs go through sexual and reproductive services discrimination. Their study revealed that these people are actively discouraged from having children either due to doubts of their ability to care for their child or possible risk of child inheriting a hereditary condition. Smeltzer *et al*., 2016 also observed that WWPDs were told out of ignorance by their care providers that they should not get pregnant and have children due to their disability. In some instances, they abuse them for getting pregnant, which bring pain and anger on the client. As sited in WHO (2009), International Conference on Population and Development Programme of Action (ICPD PoA) recognizes: "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (p5). PWDs are entitled to the right to decision making regarding their reproduction, free of discrimination, coercion and violence, as articulated in human rights documents (Glasier *et al*., 2006). Maxwell *et al*., (2007) in their studies noted that women with disabilities are regularly turned away from prenatal, labour and delivery and post-natal services when they visit the facilities, claiming that they should not be pregnant. Meanwhile, WWDs are increasingly deciding to have children or become mothers (Lezzoni *et al*., 2013; National Council on Disability (NCD) 2012; Mitra *et al*., 2015). Similarly, WHO (2009) also said that stigma against PWDs sometime result in denial of services or delay of critical health services which in some cases lead to client's death. The stigma does not also exclude refusal of the right of PWDs to health care information and the freewill to make decisions.

Stigma, discrimination, and disrespect for PWDs in our society may result to denial of their privacy and confidentiality during health service delivery. An environment where there is no privacy does not promote patient to willingly disclose his or her health problem. It makes the patient feel ashamed to express themselves freely (Maguire, 2000). Article 22 of United Nations Convention (2006) declared equal rights of PWDs to privacy, including their personal health information. Yet this is often absence during care delivery. Okafor *et al.*, (2015) and Rugoho and Maphosa (2017) observed in their studies that health care providers offer care that is not confidential, lacking privacy, and disclosure of sensitive patient information without their consent to third party.

2.2.4 Time Factor

Time is an important variable in determining the likelihood of client utilizing a health facility. It is said that time is precious and as such every individual wants to make use of it appropriately to accomplish a task, earn income or rest. It is therefore likely that clients would access a facility if time spent to access the services is short and vice versa. Ahumuza *et al*., (2014) said long queues at the health facilities waiting to source service are the main challenges that PWPDs face while trying to access SRH services. The discomfort in queuing for long at the health facility will be greater among PWPDs than those who are not, most especially when there are no comfortable seats at the facility. By convention in Ghana Health Service, persons with disabilities should be attended to first before other able persons especially when they are pregnant. Unfortunately, some health care providers rather give that support to able relation of theirs. Some health care personnel favour their own friends and relatives when providing services at health facilities (Alister, *et al.*, 2017). Queueing for long at the health facilities has the tendency of discouraging persons living with disabilities from accessing health services (Alister, *et al.*, 2017). It was also observed that client may leave the health facilities without receiving the needed services or fail to come to the facility if the waiting time is long or when there are long queues (Sokhela *et al*., 2013). A study by Oredola and Odusanya (2017) observed that patients prefer private facilities more notably because of short waiting time.

2.3 Attitude of Health Care Provider and Other Clients

Health care providers have a huge responsibility to encourage, support, and provide appropriate services to all clients both able and disabled and respective of their identity. Persons with disabilities are entitled to respect, dignity, and the right to good health care like any other person while seeking services. It is not just a right, but it increases the likelihood that PWDs will be willing to use the services subsequently. Whereas some health care providers' attitudes are described as good, respectful, great among others, (Mitra, 2016), many are not sensitive to the difficulty of women with disability (Ganle *et al*., 2016). Most health care providers treat people with disabilities quite well whereas other health staff show poor attitudes towards them that serves as a barrier for accessing health services *(*Alister, *et al.*, 2017; Bremer *et al*., 2017). Lam *et al.,* (2010) observed that, negative attitudes of health care providers influence the quality of care that WWDs receive from them. Evidence proves that able women were intimidated, scolded, or abused while seeking reproductive health care (Yakong *et al*., 2010; Alister, *et al.*, 2017; Ishola *et al*., 2017). Therefore, it may be worst to the disabled women who are marked with stigma and more vulnerable. This negative attitude is often perpetuated by health staff that should serve as patient advocates such as nurses and midwives. Rugoho and Maphosa (2017) observed in their study that female nurses are major offenders in insulting women with disabilities when they are pregnant and visit hospitals.

Although it is common for WWPDs to experience poor reactions from their family members and health care providers when they are pregnant (Powell *et al.,* 2017; Andrews and Ayers, 2016; Tarasoff, 2015; Kallianes and Rubenfeld, 1997; Kuttai, 2010; Lipson and Rogers, 2000), it will not also be surprising if PWDs fail to access RHS when health care providers show negative attitudes towards them. Unfavourable relations with health care personnel, as well as poor attitudes, and signs of insensitivity, PWDs may avoid seeking medical care or health promotion programs and activities (Smeltzer *et al.*, 2010; and Ahumuza *et al.*, 2014). Similarly, it has been observed that some WWPDs have experienced poor relations with health care providers in the past and thus may avoid the usual health care setting (Powell *et al.*, 2017; Andrews and Ayers, 2016; Tarasoff, 2015). Poor attitudes of health care staff towards WWDs make it difficult for them to visit health facilities to seek services on their sexual and reproductive health (Rugoho and Maphosa, 2017). The relationship between health care providers and PWDs was described as insensitive and lacking awareness of disability issues as they provide reproductive health care (Becker *et al.*, 1997).

Although Gibson and Mykitiuk, **(**2012) claimed Health care providers demonstrated high value for caring attitude and advocacy in helping PWDs to access services in their study, many researchers observed the contrary. WHO (2009) observed that midwives failed to see women with disabilities at the community level, claiming that the delivery process requires the help of a specialist, which is essentially not the case. Similarly, research revealed that many physicians do not conduct pelvic examination on women with a disability if staffs perceive that lifting client onto the examination table poses difficulties or is not allowed under the facility's policies, or if contractures, or pain create positioning problems (Nosek *et al.*, 2001). These negative attitudes are more likely to occur in public health facilities where supervision is low. One of the key reasons most patient or clients prefer a private health facility is good attitude of staff (Oredola and Odusanya, 2017).

2.3.1 Skills of Health Staff in Client Care

Quality health care delivery requires special skills through professional training to enable professionals deliver quality care to clients or patients according to the health needs of the individual. In the professional training of health personnel in Ghana, it appears less attention is paid to the care of persons with disabilities. This is evidenced by lack of sign language interpreters among health professionals in our health facilities to cater for the needs of speech impaired persons and materials to aid other categories of disabled persons. It was observed in a study that medical staff in developing countries have very little or no training in sign language and therefore find it difficult to communicate effectively with speech and hearing impaired women during health service delivery (Margellos-Anast *et al.,* 2006). Most clinicians do not receive formal education or training about caring for WWDs during their professional training Smeltzer *et al.,* (2019). Health staffs lack communication skills to communicate with women with speech and hearing impairment during reproductive health delivery (Taouk *et al*., 2018). Health workers are inexperience to handle PWPDs or even fear them (Ahumuza *et al.*, 2014). Their lack of knowledge and skills concerning PWDs could be a barrier to quality service delivery. Taouk *et al.*, 2018) observed that inadequate knowledge, and unawareness of guidelines of care of persons with disabilities at health facilities can significantly thwart health care providers' work of providing complete reproductive health care to women with disabilities. Available evidence proves that a lot of health care providers do not have knowledge regarding the dealings of pregnancy, labour/birth, and disability (Begley *et al.*, 2010; Lipson and Rogers, 2000; Nosek *et al.*, 2001; Rotheram and RNC Midwifery Society, 2007; Smeltzer, 2007). Most obstetricians who are specialized in high-risk pregnancies management have limited training regarding disability-specific pregnancies (Kuttai, 2010; and Rogers, 2006). Health professionals tend to view PWDS who are pregnant as liabilities and consider most as high risk and therefore intensify their fears (Walsh-Gallagher *et al*., 2011; Tarasoff, 2017).

Interestingly, these persons have special needs that must be identified, well understood, and given the needed technical care by these same care providers. Ganle *et al*., (2016) in their study also affirmed that health care staff lacks the requisite knowledge about WWDS needs and care. Hence, these challenges have decreased the desire of women with disabilities to access and use skilled maternal health care services. There is an increasing population of PWDs, coupled with the immergence of their right to health care service. It is therefore obvious that health care providers should be well abreast with the skills to handle these vulnerable individuals in society. When providers are not well educated, WWDs health care could be inadequate and has the tendency to result to state that can cause harm to the client (Gibson and Mykitiuk, 2012). In the same vein, Piotrowski and Snell (2007) and Ganle *et al.*, (2016) described health care providers' lack of knowledge about the health care needs of WWD as more worrying barrier to access health care.

It is important that health care professionals understand that WWD represent various cluster of women experiencing a diversity of disabling conditions that need unique or individualized plans of care to suit their condition. When physicians have no knowledge that PWDs are sexually active and assume that their sexual rights are not an important issue to them, there are chances that they may not offer RHS to this marginalise individuals at the point of service delivery (Nosek and Simmons, 2007). Few health care providers seem to have good knowledge about and comfortable with providing health care especially sexual and reproductive care to WWDs. The care providers often show a lack of knowledge, responsiveness, and sensitivity to issues pertaining to disability and women's health care needs. Smeltzer *et al*., (2007) study also found out that health care personnel were neither well-informed in disability issues, nor sensitive to their needs as healthcare workers failed to understand that WWD could have boyfriends / husbands or be sexually active, and as such denial them educate or inquire about their reproductive health.

Health care is a teamwork that is collaborated among various professionals with their respective expertise to contribute to the care of their clients. Rogers (2006) notes that, group effort among different types of health personnel, women with physical disabilities, and their social supports, is critical for helpful reproductive care practices. Recommendation by many researchers is that a multidisciplinary health care team discuss with the patient and her relations to develop a formal written birth plan prior to delivery (Rogers, 2006; Rotheram and RNC Midwifery Society, 2007; Smeltzer *et al.,* 2007). Good communication and harmonization among these care providers is however crucial to avoid unnecessary treatment, reduce injury, and promote quick recovery (Kuttai, 2010; Lipson and Rogers, 2000).

2.4 Health Education/ Information and Communication

Health education or information is very crucial in health care delivery. Every client or patient require health education because it offer them opportunity to know how to take care of themselves or take control over their health and thereby improve health. A sound mind adult and educated individual could comprehend health education or information better. Evidence revealed that low educational level of an individual is associated with

low health literacy (Weiss, 2003; Rudd, 2007; Heide, *et al.*, 2013).

When health information is given, it reduces medical errors and increase safety of the patient or client. Despite the importance of health education and health information through effective communication, many patients and client do not get enough of these services. This could be worse among disabled persons especially issues regarding SRH.

The attitude of health staff and physical problems create communication barriers among WWDs and health care providers which often makes the women described them as arrogant or demeaning (Smeltzer *et al*., 2007). The WWD have a common lack of knowledge on reproductive health and therefore the need to provide education directly through the community and schools, or information campaigns and health education sessions in local health centres (Breme *et al*., 2010). Evidence suggests that women generally learn about sex primarily from their friends, and among the younger ones, more information is gained from school and peers (Nosek *et al*., 2001). Reproductive health information sessions are very useful not only for purpose of education, but also put together able persons and disabled women to work to remove barriers, reduce stigmas against WWD that will positively influence community perceptions about disability (Bremer *et al*., 2010). Unfortunately, social isolation experienced by women with disabilities coupled with the label that they have no interest in sexuality, denies them the opportunities to interact with their peers to gain SRH information.

Access to information is a major obstacle to many individuals with disabilities. It is either the information is not readily available or is in a format that is not easily accessible to the particular needs of the client (Shakespeare *et al.,* 1996). WHO (2009) observed that PWDs more often do not get even the most fundamental information about SRH and as a result they remain ignorant of basic facts. Studies have showed that a lot of women with physical disabilities were observed to have received little information regarding sexual and reproductive health and how their disability may affect their childbearing and vice versa (Begley *et al*., 2010; Kuttai, 2010; Lipson and Rogers, 2000; Prilleltensky, 2003; Rogers, 2010).

It is the right of every patient/client to be provided health education or information through means that will be appropriate to the person. Article 21 of the UN convention (2006) recommends that information that is designed for the public should equally be provided to persons with disabilities in more accessible formats and technologies appropriate to different kinds of disabilities at the right time without additional cost to them.

It is necessary to employ the best communication skills to achieve an effective education or information dissemination. Health communications require care providers to clearly explain to WWDs regarding services or their conditions and the purpose of treatments, any side effects of treatments, and verify whether they understand the explanations clearly. To improve interpersonal communication with patients, care provider should speak slowly and spend ample time with patient, use plain language devoid of medical jargons, show or draw visual images, reduce the amount of information provided and repeat it, demand feedback, and create an environment that is free from shame (Weiss, 2003). When the patients feel ashamed of their ignorance or are hesitant, they will avoid seeking explanation to health issues and lead to inadequate consultation which does not lead to the right outcome for the patient condition (Maguire, 2000). It also involves giving ample time and opportunity to patient to ask questions and provide answers to them (Nicole *et al.*, 2003). They also concluded that communication can be enhanced during service delivery if care providers use non-technical language, frequency smiles and nods, good eye contact, and voice quality. The use of patients and clients' mother tongue in the delivery of health information is also vital in promoting better patient-provider relationships (Nicole *et al.*, 2003). Communication can improve patient/client's health outcomes as they are more likely to understand information if the providers communicate well. Building a continuing discussion can help solve social, psychological, and structural barriers to communication (Coulter, 2002).

Those who are visually challenged or hearing impaired will require special care when giving health education or information. To provide specialist health care services to these persons, it is necessary to communicate health information in other form like using large print, Braille, audio, and picture design. It is also important to speak slowly and clearly to the individual to ensure comprehension; employ demonstration method of teaching, sign language interpreting services; and provide readers to the client (WHO & World Bank, 2011). Mprah, (2013), and Rugoho and Maphosa, (2017) also observed that women with speech and hearing problems have little access to reproductive health information. Health care providers could not take health history or educate women with speech and hearing impairment (deaf and dumb) at health centres during antenatal care even though the client could communicate using sign language (Mulumba *et al.*, 2014). Their study also revealed that these women have problems when they go to the health centres to give birth as they cannot understand the instructions of the midwives, which result in the death of their children. Sometimes health care personnel are impatient with hearing and speech impaired persons when they have communication challenges and ignore them (Alister, *et al.*, 2017).

When there is insufficient health information about good practices on prenatal care and the rights of women, most women will not know their rights and the procedures that comprise optimal care (Baldisserotto *et al.*, 2016). This therefore makes it difficult or impossible for women to accurately assess their care if they are not familiar with what is considered to be good quality childbirth care.

Sometimes society including health staffs do not recognise the need for SRH education for WWD. These persons accessing information concerning sexuality and seeking reproductive health care is mainly difficult as they are usually perceived as nonsexual and have no need for this form of care (Piotrowski and Snell, 2007). It is also more likely that women with disabilities will not receive common information pertaining to SRH issues, get family planning services, and when they become pregnant, they may not have access to maternal care (prenatal, labour and delivery, and post-natal) services as compared to able women (WHO, 2009). Similarly, a study has revealed that WWPDs do not receive the same quality of gynaecological health care like their peer able ones (Nosek *et al.*, 2001**)**. It is not easy for this vulnerable group to get right information about family planning methods that would be safe and effective to suit their condition or disability (Nosek *et al.*,2001).

To deliver good health education some materials or teaching aids are necessary to enhance better teaching and understanding. These materials will be more helpful to persons with disabilities especially those with hearing, speech and visually impaired. Roberts, (2006) noted that deaf women are usually denied adequate information due to challenges in communicating in sign language. The visually impaired persons have no access to information on SRH in other formats suitable to them such as braille, enlarged print or audio compact disks (Mavuso and Maharaj, 2015). WHO (2009) states that lack of information and communication materials such as materials in Braille, large print, simple language, and pictures; and lack of sign language interpreters also serves as a barrier to person with disabilities to access reproductive health.

2.5 Perception of women with disability on society's attitude toward them accessing RHS

Society perception and treatment of PWDs also influence the impression these people also form about former. If the society have positive perception about PWDs, it is most likely to be translate into good treatment and vice versa. Likewise, if society have positive mind about PWDs, they will also appreciate it and reciprocate. There is sufficient evidence that society have negative perceptions about PWDs. The negative perception and stigma against disability has led to misconception and false believes that PWDs are not sexually active, nonsexual, have no interest in sex, or in capable of participating in sexual activity (Nosek and Simmons, 2007).

Observation revealed that PWDs perceived community and family members, and some health care workers' treatment given to them as that of animals and attributed the maltreatment they experience to be very much rooted in the culture (Mulumba *et al.*, 2014). PWDs are often treated with some level of disrespect in families and society. The disrespect and discrimination may lead to societal exclusion, maltreatment, and possible oppression in all aspect of life including area of reproduction. Persons living with disabilities are so much offended and concerned about the labels and stigmas that are attached to them in Ghanaian society (Baffoe, 2013). His study revealed that PWDs perceived Ghanaian society as one without regard and respect for them in all aspect of life including, work, transportation, health among others.

Evidence has also showed that WWDs receive inadequate support from family, members of community and the health care providers during RHS perhaps due to negative perceptions society hold about disability and reproduction (Ganle *et al.*, 2016, and Powell *et al.*, 2017). Further evidence suggest that some community members are not willing to assist persons with disabilities because of fear and stigma (Alister, *et al.*, 2017).

These treatments are not completely new to PWDs. Study revealed that WWDs anticipate that they would encounter negative attitudes from both staff and other clients when accessing reproductive health services (smith *et al.*, 2004). The stuff and other clients become surprised by a disabled woman getting pregnant and turn to ask them nasty questions. Though WWDs are aware that all women including both with and without disabilities might be treated poorly, many perceived that their disability worsen this abuse from health care providers (Devkota *et al.*, 2017)

It was observed that many women with disabilities perceived that the attitudes of health care providers and their understanding about disability and RHS were negative and discouraging (Devkota *et al.*, 2017). Smeltzer *et al.*, 2016 also observed that WWPDs were discouraged out of ignorance by their care providers that they should not get pregnant and have children due to their disability. In some instances, they abuse them for getting pregnant, which bring pain and anger on the client. Maxwell *et al.*, (2007) in their studies noted that women with disabilities are regularly turned away from prenatal, labour and delivery and post-natal services when they visit the facilities, claiming that they should not be pregnant.

Other study revealed mixed findings regarding WWDs perception of health care providers' attitudes towards them. As some of the WWDs express general positive experiences with health care providers, others do not (Devkota *et al.*, 2017).

In conclusion, literature suggest that transportation challenges, funds, unfavourable relations with health care personnel coupled with negative attitudes, insensitivity, and lack of knowledge regarding the needs of PWDs may serve as barriers to seeking medical interventions or health promotion programs and activities including reproductive health by PWDs.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter described the steps involved in the conduct of the study and focused on the following: study setting, research design, study population, sample size, sampling technique, instruments for data collection, data collection procedure, data analysis method, data quality control, ethical consideration, and dissemination of findings. It also discussed limitations of the study.

3.1 Study Design

The study was grounded in ethnographic research; a qualitative study that has cultural beliefs and societal behavioural and attitudinal dimensions towards PWDs. The method helped the researcher obtain experiential account of participants' stories in their own words and local context in accessing RHS (Roper and Shapira, 2000; Fetterman, 2010).

Qualitative method was used for the study using basic descriptive design to explore the experiences of WWDs in accessing reproductive health services. This method was deemed appropriate because the emphasis of the study was to explore the experiences of WWDs. The method can best produce deeper understanding of the issues and most appropriate where there is deeper understanding of human experiences, behaviour and attitude, feeling and interpretations given to such phenomenon under investigation (Vaismoradi *et al*., 2013).

3.2 Study Setting

The study was conducted in Bolgatanga Municipality in the Upper East Region of Ghana which also serves as the seat of Administration of the region. According to

GSS (2012), the Municipality has a population of 122,464. The population density of the Municipality is 155 persons per sq.

The municipality is diverse with multi-ethnic groups. However, there are about five major ethnic groups in the Municipality namely the Frafra, Kassena, Builsa, Dagaaba and Kusaasi. Common languages spoken include Grunne and Kassem. The main occupation of the people of the area is farming. It has a small landmark with sparse vegetation. The municipality shares boundaries with Talensi District to the south, Kassena-Nankana Municipality and Kassena-Nankana west district to the west, Nabdam District to the East and Bongo District to the North. In 2010 population and housing census, Upper East region's disabilities records revealed 14.1% physically challenge, 11.8% hearing impaired, 5.4% speech impaired and 30.9% visually impaired (GSS, 2012).

The Municipality has the following health facilities; one (1) public hospital, two (2) private hospitals, six (6) health centres six (6) clinics, and two (2) quasi clinics. There are also eight (8) functional CHPS compounds and five Outreach CHPS in the Municipality. All the above-mentioned health facilities provide RHS to clients including PWDs.

3.3 Study Population

The population for this study included all women with disabilities such as physically challenged, visually impaired, hearing impaired and speech impaired who were within the reproductive age and living in the municipality as at the time of conducting the study.

3.4 Inclusion and exclusion criteria

3.4.1 Inclusion Criteria

The study included disable women within the reproductive age group and lived in the municipality. In this study women age between 15 years and 49 years were considered as those within the reproductive age (WHO, 2006).

3.4.2 Exclusion criteria

The study excluded WWDs but outside the reproductive age range. It also excluded WWDs who do not or have not live in Bolgatanga Municipality for at least one year. Besides, women with intellectual disabilities were excluded from the study because of the complex nature involved in evaluating mental disability and the researcher's limited understanding in undertaking such assessment.

3.5 Sample size Determination

In total, twenty-four (24) respondents with various disabilities (9 physical, 8 visual and 7 speech and hearing impaired persons) were selected for the study in the Municipality. In qualitative studies, saturation of data is key during data gathering to determine the number of participants that are required for the study at a specific phenomenon. Saturation means the point at which data collection process has repetitive information with no new important information gathered from individual interviews or focus groups, or no new information is believed loss, the researcher ends interviewing the rest of the participants (Rothmans *et al.*, 2009; Polit and Beck, 2014). In this study, having conducted three FGDs with WWPDs, women with visual impairment, and women with speech and hearing impairment, and interviewed individuals, the information gathered was repetitive suggestive of saturation hence the researcher stopped recruiting more participants.

3.6 Sampling technique

The respondents were purposively stratified to include all the three major forms of disability because of the possible differences in knowledge, experience, and ability to communicate experiences and opinions in reproductive health issues.

The strata included physically challenged, visual impaired, and speech and hearing impaired women. A list of women within the reproductive age was extracted from the Municipal disability register considering the various strata. Due to the limited number a researcher needs to use during in-depth interviews as well as focus group discussion, the required numbers were picked out of the whole study sample and finally engaged.

3.7 Data collection procedure

Three focus group discussions were conducted to source data on participants' experiences in accessing RHS at the health facilities within the Bolgatanga Municipality. There were nine (9) PWPDs, eight (8) visually impaired, and seven (7) speech and hearing impaired constituting the group for the respondents. In furtherance to assessing the respondents' experiences, an individual in-depth interview with WWDs was conducted at their residences and other places convenient to them in the municipality. Out of these 24 respondents, twenty (20) were then selected for the in-depth interviews. The information was obtained until a point of saturation was attained. Interviewing respondents in the presence of any other person was avoided to ensure privacy and confidentiality. However, participants with speech and hearing impairments were interviewed with the help of sign language interpreter, or the family member who assisted for better communication. Each interview lasted between 45 minutes to 1hour. At the beginning, the participants had the general topics explained to them and encouraged to express their ideas freely.

Three research assistants with some experience in qualitative research and knowledge of local dialect of the area were used to conduct focus group discussion and gathered information from the individual in-depth interview using the interview guide. An audiotape recorder was used to record verbatim the sessions. The themes that emerged from analysis of the interviews were identified and translated into English, which was then coded, cleaned, and analysis.

3.8 Data Collection Tools

Data was collected using structured interview guide. The questions we grouped in sections. Thus, demographic data, access, stigma, attitude of health care providers and other clients, and information and communication. The demographic data had nine (9) questions while the rest of the sections contained twenty-eight (28) main items and some sub questions. The interview guide was used to gather demographic and economic data such as age, sex, religion, marital status, education level, type of employment, main source of income, and number of children. The guide was also used to obtain information from respondents on their experiences in relation to accessing RHS; stigma and discrimination; health education, information and communication; and attitude of health care providers and other clients during the service. Audiotape recorders were also used to record the sessions. Besides, the researcher also used pen and field notebook to write down important points during the interview and focus group discussion as backups.

3.9 Pre-testing

Three research assistants were use in the data collection process. They both had a minimum qualification of Diploma and with some level of experience in the data collection. Language was the other criteria in selecting the assistants. These Research Assistants were engaged on one-on-one basis to discuss the study questions and to ensure that they were conversant with the interview guide and can give the right translation of question into Grune (the native and widely spoken language of the study area) and sign language for easy understanding to WWD. Each Research Assistant interviewed three WWDs in Bongo District, Upper East Region with the tool to access the ease of use, and the necessary modifications made before carrying out the study.

3.10 Analytical Framework

Data analysis was guided by Braun and Clarke (2006) framework for thematic analysis. According to them, thematic analysis entails searching across a data set, thus a number of interviews or focus groups, or a range of texts in other to find repeated patterns of meaning. The process involve in this analysis includes: (a) familiarising self with your data, (b) generating initial codes (c) searching for themes (d) reviewing themes (e) defining and naming themes and (f) producing the report. Using this framework of finding the themes the researcher will not only be interested in majority responses in a theme but also minority as well, provided it contains important data in relation to the study. The ‘’keyness‟ of a theme is not necessarily dependent on quantifiable measures but also in respect of whether it captures something important in relation to the overall research question (Braun and Clarke, 2006).

According to Braun and Clarke (2006), to enhance quality of data, all transcripts should be frequently revisited to make sure there is exactness in the translation of context and spoken words from local dialect into English language.

3.11 Data entry and cleaning

Data gathered by audiotape was transcribed and translated verbatim from Grune by the researcher into English language and verified with experts in Grune language. This was written down and typed.

All the transcripts were coded, cleaned, and categorized into identified themes.

Interpretations was made on the various themes as reported in ensuring that the data provided a concise, coherent, logical, and interesting account of information in both within and across themes. Where appropriate, word for word quotations and narratives from interview transcripts was used to illustrate and support interpretations of the data.

3.12 Data management

This is the method of ensuring that information gathered is kept safe to prevent loss or third-party except supervisors of the study from getting access to the information. The data gathered from the participants of the study included field notes, audio recordings and transcripts. To ensure their safety, the audio recordings were stored onto personal computer and external hard drive. The transcribed data from the recordings were carefully crosschecked to be sure is exactly as the recording and store. The transcribed documents were labelled with each participant’s voice identity number, saved and passworded. besides, the hard copies of the data were produced and kept in safe place as backup.

3.13 Study Limitations

This study was intended to explore the experiences of WWDs seeking RHS in the Bolgatanga Municipality and may not be generalized to other settings. The researcher limited the study to this setting due to inadequate finance. The general attitudes of respondents towards research in general may also serve as a limitation that may not allow for generalization. A bigger population and thus bigger sample size would probably produce more evidence to allow for generalization. Besides, negative attitudes of respondents will mean less genuine responses from respondents. Recall bias cannot be ruled out because the respondents might have forgotten their experiences over a period.

3.14 Dissemination of findings

On completion of this study, the researcher seeks to disseminate the finding with all stakeholders including chiefs and assembly men, federation of persons living with disabilities in the region, municipal assembly through durbars. Also, the findings would be shared with Ghana health service, and policy makers through meetings, professional conferences and publications in health related journals for the public access.

3.15 Ethical Consideration

To meet ethical standards, an introductory letter was given to the researcher by University for Development Studies to conduct the study. In addition, permission from the District Assembly (social welfare unit/ persons with disabilities association) was sought for approval before the research was conducted. The Chiefs, Elders and Assembly members of the area were equally informed of the exercise and permission obtained. At the time of interview, the informed consent was read and explained to respondents as most of the respondents in the study area had little or no formally education. Written and verbal consents were obtained from all participants depending on what was most convenient to participants. Individual participants were requested to sign or thumbprint a written informed consent form. Those who could not sign or do not feel comfortable to sign the written consent form were allowed to give verbal consent. However, verbal consents were witnessed by either one family member or friend and tape-recorded. During data collection, other persons' presence was avoided to ensure privacy and confidentiality. Participants were also informed that participation was voluntary, and one could withdraw from the study at any time if they desire to do so without any consequences.

CHAPTER FOUR

FINDINGS

4.0 Overview

This chapter is categorised into two parts. The first part deals with the narrative of the socio-characteristics of the participants and the second section describes in detail the findings from the participants which has been put into themes.

Participants were assigned numbers during the interview in order not to reveal the identity of the participants and at the same time for easy identification. The numbering started with 01, representing the first person, followed by 02 up to the last person which was 24 in the same sequence. This was done to avoid using names of the participants to ensure their privacy and confidentiality. The participants expressions were used to describe their experiences in accessing reproductive health care in the municipality. During the interview, participants facial expressions, gestures, and other nonverbal communications were taken note of and reported. Verbal quotations of interest were made using participants identification codes.

4.1 Socio-demographic characteristics of respondents

This section focuses on socio-demographic characteristic of the respondents which include age, marital status, occupation and income, level of education, number of pregnancies and children, and type of disability

4.1.1 Age

Age is an essential variable in this study considering its implication for reproductive health matters and other related issues. The dominant age group was between 31 - 35 years constituting 33.3%. The was no respondent within the ages of 15 and 20 years.

4.1.2 Marital status

The information on respondents' marital status is relevant in the study to help understand some demographic and health indicators. The variable is a key indicator often times needed to make some decisions when providing reproductive health care services. Besides, it talks about the support that the respondent will receive from the partner to access RHS. The findings revealed that most (54.2%) of the respondents were single.

4.1.3 Occupation and income

Another vital socio-demographic variable in the study, relates to occupation of the respondents. Enough evidence has shown that there is a correlation between employment and income of an individual. This is because one's income status can influence the person's health seeking behaviour including RHS. The findings of the study showed that, more than three-quarters of the women were engaged in menial jobs like weaving, petty trading among others that earn them inadequate income as little as 4,000 and below per annum.

4.1.4 Level of education

Education is a key in providing knowledge and skill that can enhance quality of life of every individual. Health seeking behaviour of many people most especially reproductive health are largely influenced by the level of education of the individual. It is most likely that individual with low education will not take reproductive health serious like the high educated ones. Among other variables, the study also sought to explore the relationship between the level of educational level of WWDs and access to RHS. It was observed in the study that a little over one third of the respondent had attained secondary education.

4.1.5 Religion

The religion of every individual influence the behaviour, perception and attitude in all aspect including health care. The belief system of the respondents can influence their perception to seek reproductive health services. The dominant religious group in the study was Christians who formed 87.5% of the whole respondents.

4.1.6 Number of pregnancy and children

Woman getting pregnant and having children are positive indicators for need for reproductive health care to ensure the health of the mother and child. Accessing reproductive health care at this critical period will help prevent complications and maternal and child death. The findings of the study revealed that 83.3% of the respondents had ever been pregnant and have children.

4.1.7 Type of disability

In this study, the researcher deemed it necessary to classify WWDs by type of disability to explore their experiences in access RHS. This was done purposely to understand the experiences in the various classifications as they may not experience same. The various types of WWDs covered were physically challenge, visually impaired, and hearing and speech impaired. Physically challenge constituted nearly half of the respondents.

Table 1: Demographic characteristics of respondents

Variable	Frequency	Percentage (%)
Age		
15 20	0	0
21-25	3	12.5
26-30	5	20.8
31-35	8	33.3
36-40	5	20.8
41-45	3	12.5
Marital status		
Married	8	33.3
Single	13	54.2
Divorced	1	4.2
widow	2	8.2
Occupation		
Trader	7	29.2
Weaver	8	33.3
Seamstress	4	16.7
Head dresser	1	4.2
Teacher	1	4.2
National service	1	4.2
Unemployed	2	8.2
Annual Income (Average Amount GHS)		
Less 1,500	5	20.8
1,500-2,000	9	37.5
3, 000-4,000	8	33.3
5,000 and above	2	8.3
Level of Education		
No formal education	4	16.7
Primary	6	25.0
JHS	5	20.8
SHS	7	29.2
Tertiary	2	8.2
Religion		
Christianity	21	87.5
Muslim	3	12.5
Traditional	0	0
Number of children		
None	4	16.7
One (1)	8	33.3
Two (2)	6	25.0
Three (3)	4	16.7

Four (4)	2	8.3
Number of pregnancies		
Never	3	13.0
One (1)	5	21.0
Two (2)	7	29.0
Three (3)	7	29.0
Four (4)	2	8.0
Types of disability		
Physically challenged	9	37.5
Visually impaired	8	33.3
Hearing/ speech impaired	7	29.2

4.2 Overview of themes

Interview with WWDs came out with five main themes. These themes include Accessibility, Social Stigma and Discrimination, Time Factor, Health Education/ Information and Communication, and Attitude of Health Care Provider and Other Clients.

4.3 Main themes and subthemes of the study

Table 2: Main themes and subthemes of the study

Main themes	Subthemes
Accessibility,	Transportation from home to health facilities
	Health facility environment experiences
	Finance
	Health care providers
	Services and commodities,
Time Factor,	Time spent/ wasted time
Social	culture
	Stigma and Discrimination,
	Social support
Attitude of Health Care Providers and Other Clients at the Health Facilities	Respect
	Dignity
	Support
	Privacy and confidentiality
Health Education/Information and Communication,	Types of health education
	Nature of their condition or service,
	The purpose of treatments/service, their side effects and treatments/service options.
	Clarity and challenges of the education or information

4.4 Access to Reproductive Care Services

All the respondents of the study have visited health facility for reproductive health care service within the municipality in the past. They visited both public and private health facilities in the municipality. Most respondent visited the public health facility especially the Upper East Regional Hospital, Bolgatanga to sought at least one of the following services. Thus FP, ANC, PNC, STIs treatment or childbirth.

The respondents alluded to the fact that reproductive health services are so beneficial to them because through the service, mothers and their babies get good health. They also get education on FP to space childbirth and other reproductive health services. Some of the respondents stated:

> *"The hospital delivery is very good because the ANC we normally get when we are pregnant helps in early detection of some health problems and timely intervention which helps to promote safety and reduce pain on our day of delivery. if you attend ANC at the health facility, delivery is easier as compare to those who don't go to health facilities".* **voice number 04**

> *"The hospital is very good, because at the ANC care, they give us medication to take for the nourishment of the unborn child and during my second delivery, they detected that my baby was big so the doctors did caesarean section to bring out the baby".* **Voice number 06**

> *"The midwives do tell us to keep ourselves clean and we should maintain good personally hygiene in order to give birth to healthy babies. It helps a lot because they handle you well and you can get a safe delivery".* **Voice number 03**

4.4.1Transportation from home to health facilities

It was found out that most of the respondents went to health facility for services by foot. However, it was not a major problem to some of them as the health facilities they sought services from were not far from their homes. Only a few of them were able to board public means with some challenges. A few others especially the physically challenged also use their personal tricycles or motor bikes owed by the family. Despite that, others still encounter a lot of difficulties with transportation to the health facility. Those who faced the transportation challenges stated lack of help to facilitate, easy movement in and out of the public vehicle, cost of transportation involved if they have to take public means, and difficulties paddling tricycle to health facility as their problems. In an individual interview, a physically challenged woman had this to say:

> *"I was pregnant and have to paddle a tricycle to climb hilly areas to health facility. It was not easy for me. I did not get support from any one to be pushed to make it easy. That period, anytime I went to health facility on my tricycle, I could not sleep. I will be very tired"*. **Voice Number 01**

One other physically impaired woman stated:

> *"it's always a problem because I stay with the 'can do'' driver but anytime he's not available I have to take a taxi for dropping which is very costly"*. ***Voice number 6***

It was also revealed that some drivers and tricycle popularly known as "Mahama can do" riders do not want to pick physically challenged persons because they feel the passenger will waste their time or require some support to enter or alight from the vehicle. Some other passengers on board also grumble because they feel disturbed of space to accommodate these women and their walking sticks. One of the physically challenge women said:

> *"The riders feel we are delaying them because we have to take time to enter so that we don't fall. Some passengers also complain. You will hear them grumbling. Some of us require help to enter the vehicle. It is not easy''.* **Voice number 05**.

Another one said:

> *"I entered a "can do" to hospital for ANC visit and the passenger who was a female was grumbling and eying me. I could see that she was not happy but what will I do. I manage to enter and ignored her".* **Voice number 08**

4.4.2 Finance

Cost of transportation was also a key factor to WWDs. The respondents paid between one cedi to seven cedis (ghc1-ghc7) as transport fares which they described expensive to them considering their financial status. Sometimes they have to pay for additional seat for a relative who is supporting them to the health facility if any. Another physically impaired woman said:

> *"Transportation cost is a problem, to go and come back from the health facility is money. Any time I am going to regional hospital, I will pay like five cedis (ghc5). Sometimes I pay more especially if I have to send someone to help me, then you have to pay for extra seat and where is money''.* **Voice Number 03**.

Another visually impaired respondent also said:

> *There is no money to pay for transport to hospital all the time. Sometimes I walk with my girl who helps me to the health facility which is a bit far from my home.* **voice number 12**

The respondents also have to pay for commodities or drugs that are not available in the facilities or not covered by National Health Insurance Scheme (NHIS). According to WWDs, sometimes they make additional payments for drugs or service even if one is ensured with NHIS, what they called 'top up' payment. This means that the cost of the service or drug at the facility is more than the health insurance price therefore the client must pay the rest to meet the actual cost.

4.4.3 Health facility environment experiences

The WWDs described their experiences at the health facilities to access RHS as challenging. Most of the respondents reported that they were not able to access the health facility with ease. They outlined the difficulties as; difficulties climbing the stairs in some health centres, not able to do what the care provider asked them to do, so much delay in receiving care, competing with able persons for the service, and communication barrier among the speech and hearing-impaired women. The physically challenged women described their experiences of getting into the facilities as difficult because of the stairs and slippery tiled floor. A woman with physical impairment during interview remarked:

> *"They should always consider some of us the vulnerable when putting the steps and floor tiles. They should build pavement instead of the stairs for easy climbing and access. They should not let us join the able people queue in accessing health service"*. **Voice number 07**

Another WWPDs

> "*my problem is the slippery nature of the floors of some health facilities because of the tiles used. It makes walking difficult for us. Even those who are not disable sometime want to fall due to the slippery tiles''*. **Voice Number 01**

In a FGD with WWPDs and visually impaired women, participants also complained that the floors of some facilities are slippery because of the tiles.

4.4.4 Access to the health care provider(s)

All the respondents stated that Physician Assistant (PA), Doctors, Nurses, and Midwives are health care providers available to them. Among the health staff, most respondents prefer the Midwives and Nurses. They Said Nurses and Midwives are preferred because they are always available to them, educate and interact with clients, and care for them. The speech and hearing-impaired persons also said some of the nurses understand a little bit of sign language that enhance communication. However, few others said they prefer Doctors or PA because they have deeper knowledge in health issue and can give them proper medical care.

4.4.5 Service and commodities

All the respondents agreed that they had access to health care service from the health care providers. Most respondent also received the needed services and were quite satisfied. The WWDs are assessed physically and given the needed services. The respondents mention only palpation as an assessment done on them during antenatal visits. FGDs with both WWPDs, visually impaired, and speech and hearing impaired women also confirmed that physical assessment such as palpation, and scanning were done during ANC. The participants could not mention vital signs, weighing, history taking, inspection, and laboratory examination (urine, stool) which are routinely done in reproductive care services especially ANC as assessment.

Majority of the respondents acknowledge that most of the services and commodities were available except drugs that were sometime not available.

Many of the respondents were satisfied with the availability of the resource or commodities in the facilities they visited. In an interview with a physically challenged woman, she said:

> "*All my visits to hospital, I always meet the nurses all the time and they give me the FP pills and other drugs. I always get the type of FP pills I want. So, I'm happy"* **Voice Number 03**

It was however observed that some respondents were not happy or satisfied with commodities availability. They claimed they did not get some drugs and must buy from their pocket. This is what a physically challenge woman have to say:

> *"I'm Insured but sometimes the drugs are not there in the facility, we go to buy from outside. I used health insurances to source every service. Is only when I was pregnant that I bought most of the medications that were not available with my own money*" **voice number** 06

Another visually impaired woman said:

> *"At times I get to the clinic and none of the medications is available for me and I have to buy it with my money which is painful. I was not given drugs and when I inquired why, the response was very hash and that made me feel bad"*.
>
> **Voice number 12**

In a FGDs with physically challenge women, a participant had this to say:

> "*when I was pregnant and went for weighing, they gave me blood tonic that they usually give to pregnant women. But when I went back the next time I was told to go and buy because it was finish. It took me some days before I was able to mobilise money and went and bought it''*. **Voice Number 01**

4.4.6 Time Spent at the Facility

Time is an important factor in health care service delivery. The utilization of the service depends on how long the clients spend in the facility. It was observed that the respondents kept long in the health facilities to receive services. A physically impaired woman narrated her experience:

> "*Sometimes you will keep long at the facility before you are attended to, especially when you are to go to laboratory or have to collect drugs at the dispensary in the regional hospital. You will be in a queue annnn''*. **Voice Number 02**

A visually impaired respondent stated:

> *"It depends on how early you report and how long the queue may be. But they always take care of those that came before us small before they also skip and take care of we the less privilege ones"*. **Voice Number 13**

Another visually impaired woman also said health facilities has no protocol to identify women with disabilities for special care. She said:

> *"The hospitals have no consideration for those of us with disabilities. If we could be identified as disable persons soon as we get to hospital and get fast treatment it will be helpful"*. **Voice number 11**

These were also key points mentioned in FGD with WWPD and visually impaired women. They also explained that the delay was sometimes due to long queues and their inability to get to the next level on time; for example, laboratory, dispensary etc. This has led to some of them declining to use the services subsequently and changed to different facilities. Some have changed to other facilities, herbal clinics, or chemical shops to access RHS.

In an interview with a visually impaired woman, she had this to say:

> "*At time I go for family planning pill and some other drugs like malaria drugs at the nearby chemical shop because I cannot go to hospital alone and if a relation agrees to go with me, the person cannot come back early to do any meaningful work that day''*. **Voice Number 012**.

Those who changed to other health facilities, most of them disclosed that they received better services because they got quick services, had all the medications, and the care providers were also polite to them. One of the physically challenged participants also have this to say:

> "*I used to visit one health centre in the past for ANC and you will queue annn and at the end, you will not get some of the drugs. Sometimes they will ask you to go and buy from chemical shop. I decided to change to a different one and since then I get my service without much delay and my drugs as well''*. **Voice number 05.**

A few of the respondent who also changed facility for the same reasons experienced no difference from their previous facilities.

4.5 Social factors.

This variable focused on cultural beliefs that may influence WWDs' access to RHS, stigma and discrimination, and social support and supportive care.

4.5.1 Cultural

In view of cultural beliefs or factors that hinder access to RHS among WWDs, all the respondents stated that there is none in their respective communities. The respondents said it was things of the past and not today. The FGDs also supported this and said previously there were some cultural beliefs against persons living with disabilities in general, but it does no longer exists. There is no form of cultural influence that impede WWDs in the municipality from accessing RHS. A visually impaired in a FGDs said:

> "*It may be in the past, there are no more cultural beliefs to denial us from receiving health care services. Delivery and family planning are all encourage by health professionals, so is part of health. No one restrict us from going for such services. I delivered all my children at the health centre''*. **Voice number 13**

Another physically impaired woman in FGDs stated that:

> "*No cultural beliefs restrict us to have children. If you can take care of you children no one will prevent you to have them. I have two children already''* **voice number 08**

4.5.2 Stigma and discrimination

In line with reactions from relatives when WWDs want to seek RHS, all the respondents said they do not receive any serious negative reactions but teased by friends and family members in the form of jokes. For example, a physically challenged participant stated that:

> *"some always say we are disable and can't give birth, so what are we going there to do. what feeling do we even have, or which man will come to us that is making you go in for family planning*". **Voice Number 05**

A woman with physical impairment in FGD also said*:*

> *Some able friends also say you too what are you going there for. You can't even conceive and you are going for family planning'', ''what feeling do you have''.* **Voice Number 09**

However, this teasing does not affect their access to service. For instance, a participant stated that:

> *"when you are pregnant, they tease us. but when they say it, we don't mine them. Others say that you can't walk and you want to be having sex. But we don't mind them. We just ignore them and go for the service''.* **Voice Number 08**

Similarly, some participants also said that some able clients look at them in a surprise manner at reproductive health facilities and make negative remarks:

> *"As soon as I entered and sat down, some able clients turn and looked at each other and laughed. They look at me from time to time in a surprise way".* **Voice number 07**

4.5.3 Social support and supportive care

Though some of the women receive support from close family members, other do not. A WWPD commended the husband for his support especially regarding medical care. She said:

> *"My husband is very supportive, and we are the only two with our children in the house. I don't encounter any problem and bad reactions when going to the hospital" at times he assists me to the clinic.* **Voice number 3**

The WWDs in the municipality reported that society do not give them adequate support and supportive care to access reproductive health care services. Some of their family and community members, and even some health care providers do not give them the needed support. Family members do not accompany them all the time as needed to health facilities to offer them the desired support. Some are also denied lift by driver/tricycle riders. At the facilities levels some other clients refuse to support them. The WWDs receive inadequate compassion from the society, family members and some health care providers. A visually impaired woman stated in an in-depth interview that:

> "I usually go to the hospital with my daughter b*ecause I cannot see. She will lead me to the place but when she goes to school, I find it difficult. If I do not get anyone to support me, I cannot go. When I was pregnant, sometimes I have to let my daughter absent herself from school on scheduled days to lead me there''.* **Voice Number 14**

Another one also said that due to their impaired vision, at times other able persons take advantage and skip or jump the queue to be attended to and leave them in the queue. She said:

> "*Because we cannot see other able clients will not tell you that it is your time to see care provider so they will skip and enter to see the care provider leaving you on the queue''.* **Voice Number 12**

4.6 Attitude of Health Care Providers/Other Clients

This domain looked at the health care providers and other clients' attitudes towards WWDs accessing RHS in the municipality. The sub themes that emerged were respect and dignity, privacy and confidentiality, and support to respondents.

On the experience of respondents with the health care providers, various opinions were expressed. Whereas some described health care providers as friendly, supportive, caring, and polite, few others hold the opposing views.

4.6.1 Respect and dignity

Many of the respondents said though most of the health care providers respect and treat them with dignity, there are some others who do not. According to them, the care providers do not isolate them, but some warmly welcome them. Many of the respondents were quite appreciative of their interactions with health care provider. One of the WWPDs had this to say:

> *''well, they received me well whenever I got there, maybe it is my luck. Any time we meet we exchange greetings and they smile towards me''* **Voice number 3**

Another one reflected on her experience and remarked:

> *''On my admission to the hospital my relative was not there, but the doctor asked the nurses to help me get my medication and they did. I had help from care providers''*. **Voice number 06**

Another visually impaired respondent said:

> *‘‘Some of them, the way they talk to me kindly and offer me seat is a sign of respect. Some of the nurses always help me take my folder and the medications as well’’.* **voice number 12**

However, some few respondents said they are not polite, and unfriendly. They were largely women with speech and hearing impairment and physically challenged women. The respondents claimed care providers are not polite in their talk, get angry with them because they cannot talk or hear, and sometimes just ignored them. As a result of these they find it difficult to ask for assistance. Hearing and speech impaired women stated that because of their inability to talk and express themselves, health care providers either laugh at them or loose temper as they struggle to understand them. The respondents also alleged that care providers delay in issuing folders to them and insulted them for getting pregnant during service delivery. Some respondents poured out their bitter experiences. In an interview with one WWPD, a mother of two children, she was so emotional about how a doctor asked her an irritating question why she should get pregnant. She said:

> “*the doctor asked me in one of my visits to regional hospital when I was pregnant, what do you need a child for. How can you ask me such a question? I even wanted to go there for an operation, but I won’t go there again’’.* **Voice Number 04**

In another individual interview with one of the physically challenged respondents, she said:

> *Some nurses are rude and don’t regard us at all. There was a time when I was delivering and due to pain, I was crying, and one used a pillow to cover my*

> *mouth in the maternity unit''. ''Hmm, some of them ignore us and even insult us''.* **Voice Number 07**

One other alleged that:

> *"When we get there, some of the nurses are always busy chatting and when time is due for closing, they will now be rushing to attend to us which is not the best. Though I do spend long hours there, I have no option. Because of my disability I can't go to far place. I sometime feel like changing a place, but distance compels me to still go there".* **Voice number 08**

In the FGDs physically challenge women, some participants also expressed similar sentiment. One of the participants had this to say as she vents her frustrations.

> *"when you get to the health facilities, some health care providers behave like our disability is infectious. They look at you and do not want to attend to you well. Some of them don't just mind us. I wonder why they do that".* **Voice Number 09.**

This comment of some health care providers viewing them as if their disability is "infectious" raised the interest of others. She was vehemently supported by other participants affirming that the observation was true.

4.6.2 Support obtained by respondents

Majority of the participants claimed they have been receiving some assistance differently from their colleagues who are able and attributed it to their conditions (disability). Some others did not observe any differences in their care in the facilities they visited. Most of the respondent who said the health care provider treat them differently noted that it was in their favour. According to them, the providers attend to them before other able persons who were there before them. However, this support had always generated controversies at health facilities as some other clients feel peeve for the support. Some able clients usually complain when WWDs are favoured to be attended to first and described former to be rude towards them. Some even suggest the creation of separate reproductive unit for WWDs. A respondent who is visually impaired said:

> *"They always complain that they came before me and why should they jump me from the row to serve me. 'Is it because she is blind or what we are all here for the service''* **Voice Number 15**

Another WWPD acknowledged:

> *When you get to the hospital other able clients seeking care at the hospital don't normally want to consider us because of our condition and when the nurses come to our aid they complain and say they are discriminating. They should create a separate unit for disability persons for easy accessibility during FP, ANC, PNC etc. they should also continue to educate on FP.* **Voice Number 03**

Though not all the care providers and other able clients, WWDs get some support from them when accessing reproductive health care. One of the physically challenged women in an interview reflected on her good experience with health care providers by saying:

> "*I was treated nicely. They helped me many times to lie down in the bed and supported me when I want to get up." Sometimes you don't even ask them for*

> *help, but they will willingly come and assist you get the services you came for*.
>
> **Voice number 01**

Another visually impaired woman also recalled this:

> "*I experience some health care providers assisting me whenever I went to the hospital. They supported me, holding my hand while I entered the hospital. They told me to walk carefully so that I don't fall". I was even advice to use a grown-up person to assist me or else if I'm not guided well and I fall it will affect me and the pregnancy"*. **Voice number**14

In FGDs, some of the participants also gave similar reports. One of the physically disable participant remarked:

> *''It is not all health care providers that are rude. I have ever encountered a polite and kind nurse who helped me when her colleague nurse attacked me with insults without provocation at the health facility. He just moved me away and attended to me''*. **Voice Number 06.**

On the other hand, many go through a lot of struggle with very little or no support. A WWPD said this in an interview:

> *''I once ask a nurse to assist me get down from my wheelchair and he said he is not the one who made me a cripple. I was surprise of the response. Just an assistance to get down too? They are always busy on their phones or watching television''*. **Voice Number 09**.

Another WWPD said:

> *''I was left in the delivery room when I was in labour for a long time without any word from midwives, no examination; nothing until the pain became too much and I cried out and they now came to attend to me. I felt very bad because they were attending to others and leaving me"*. **Voice Number 08.**

The visually impaired women also stated having difficulties locating where services were provided. In an interview with a visually impaired woman who has good anatomical structures of the eyes, but lost vision expressed her frustration on how care provider shout at her when they ask her to carry out an activity at the health facility. They hardly identify her as a visually impaired person until she prompts them that she cannot see.

> *"Any time I visit health facility for service, some nurses who don't know that I'm visually impaired shout on me thinking I don't want to carry out assigned activity. I went to a health facility for weighing of my child and a nurse shouted on me harshly because she asked me to place the child on the weighing scale and I could not locate where the scale was placed. Other clients have to assist me and told her I was a visually impaired person"*. **Voice Number 7.**

Another visually impaired woman stated that due to their impaired vision, at times other able persons jump the queue to be attended to instead of assisting them to also see the care providers in the consulting rooms. She said:

> *"Some other clients who can see take advantage and skip the queues to be attended to whiles those of us who cannot see remind seated. I went with a child one day and join the queue and the child went and was standing outside. As they were going in and out to see doctor, they did not tell me to move along*

> *rather they were jumping over me and entering. That day I delayed at the facility".* **Voice number 12**

Other respondents claimed health care provider discriminate in their service delivery as they attend to known people who came later than them first. These are mostly the care providers friends or their relatives. A physically challenge woman said:

> *"My problem is that some of the health care providers normally take the folders of those they know for treatment before us even though we came before them and I don't know it's because of my condition or what. There are times I am neglected while other able persons are treated".* **Voice Number 2**

One other respondent alleged:

> *"If you don't know any care body at the health facility to assist you, it will take you a long time for them to attend to you. Some health care providers select relatives and friends and attend to them first before those of us who don't have anybody".* **Voice number 5**

4.6.3 Privacy and confidentiality

In respect of privacy in the health facilities, an overwhelming majority of respondents acknowledged that health care providers maintain adequate privacy during service delivery. Health care providers attend to them in private rooms and do not unnecessarily expose them. They also admitted that health care providers keep their confidential information without sharing it with others who do not matter in their care. All the FGDs also affirmed these same findings. However, one physically challenged woman said during individual interview that, sometimes privacy is not adequate. She claimed her medical history was taken in the presence of other people and she was not happy. She said:

> *"In one of my visits to see doctor, I heard doctor was going somewhere, he was in hurry, so they asked me what my problem was meanwhile there were some other people around. I was not happy with that".* **Voice number 02**

4.7 Education, Information and Communication

The WWDs receive health education and information from health care providers at the reproductive health facilities in the Bolgatanga municipality. The finding was focused on the following subthemes.

4.7.1 Types of health education

On education, information and communication regarding service sought from health care providers, all the respondents said they have been receiving health education or information regarding the services. These include information on FP contraceptives, the use of Insecticide Treated Bed Net and its benefit during ANC and PNC, preparations towards delivery, the benefits of the services, and possible side effects of the treatment or services. In the FGDs with both physically disable and visually impaired, and speech and hearing impaired persons respectively, the participants also further stated that they are educated on good nutrition and administration of drugs (folic acid, iron supplements) during pregnancy, preparations towards delivery, and breastfeeding of their babies.

4.7.2 Nature of their condition or service,

The WWDs are given education or information regarding the services they sought. These were varieties of services in relation to reproductive health. Family planning, ANC, childbirth, PNC were the common services the respondent sought. They were given education on family planning and the various methods available. At ANC, they were educated on good nutrition, personal hygiene, and preparations towards delivery.

4.7.3 The purpose of treatments/service, their effects and treatments/service options.

According to the respondents, the care providers explained the purpose of the treatment/service, the effects, and other options especially FP services to them.

They were told the need for family planning to space their child births, why they should come for ANC services till delivery and to continue to PNC for their health and that of the child.

4.7.4 Clarity and challenges of the education.

The respondents reported that most of the times, health care providers spend ample time to educate them, communicate to them loud and clear in the language that they understand, and in an interactive and friendly manner. The health care providers also demonstrate how to use the commodities like FP pills and devices and drugs, to them. Sometimes they are given opportunity to clarify or ask questions for better understanding.

Some respondents however had some challenges with the education and information provided by health care providers. According to them, days that the clients are many and care providers do mass education, they hardly hear especially those at the back seats.

It was observed that the speech and hearing impaired women were worse off. All the hearing and speech impaired women were dissatisfied with the education and mode of communication during service delivery because they did not understand most of the things they were educated on. Health care providers could not communicate meaningfully in sign language to enhance their understanding. In a FGD, the speech and hearing-impaired woman revealed that the major challenge they face when seeking care at the health facilities is communication barrier. They encounter difficulties communicating effectively with care providers and observed dissatisfaction of service from some of the service providers. A hearing and speech impaired participant said:

> *"when we go to hospital, care providers feel we are wasting their time if we do not understand each other and get angry with us".* **Voice Number 20**

Another hearing and speech-impaired participant also stated:

> "*they ignore us because they don't understand us. While I was communicating to them during one of my visits in sign language, they burst into laughter and I was not happy".* **Voice Number 18**

One other speech and hearing impaired participant narrated her ordeal.

> *"Because there was no one to interpret during my delivery, I felt some severe pain but out of communication barrier, they were not able to understand me".* "*we don't feel happy going through such difficulties when they could have just employed sign langue interpreters to assist us at the facilities, especially the regional hospital. Some care providers even laugh at us as if we are not human beings"* **Voice Number 017**

Another participant in the same FGDs added:

> '*'those of us who can read and write are even better than our colleagues who cannot''.* **Voice Number 020**

Even in a FGDs with the WWPDs and visually impaired persons, a physically challenged woman expressed sympathy for the speech and hearing-impaired colleague. She said:

> "*our colleagues who are speech and hearing impaired are worse off when it comes to seeking services at health facilities due to communication problems. Because they can't hear and talk, they are not able to get better services. The health personnel don't understand their problems to give them better care due to communication barrier. They cannot present their complaints to care providers"*. **Voice Number 02**

The visually impaired respondent also said information on flip chat used by health care providers for education at ANC and family planning units were not presented in simple graphic formats, or in large print or brail to enhance those who can read to use. They only listen to the discussions and pick what they can comprehend. They could not also benefit fully in the mass education because they cannot see the commodities and the demonstrations in their usage. A visually impaired woman said this in an interview.

> *"they show us the booklet and mention the names of food, fruit and vegetables to eat and show picture to our colleagues during ANC but because I can't see I don't benefit much"*. **Voice number 12**

To conclude, the respondents made several suggestions to improve the services. The respondents suggested that to improve the service for them to use, the facilities buildings should be made disability friendly. According to them there should be ramps, and no smooth tiles on the floor. They also want to have a separate reproductive unit well-staffed with personnel who have skills in dealing with WWDs.

The health facilities should have all drugs covered by the NHIS and make them available to them to safe cost. The respondents also want staff in the various facilities to have patience with them during service delivery especially in the labour room.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter deals with the discussion (interpretation) of the research findings in relation with that of the literature reviewed. The discussion of these findings helped in broadening the understanding of the experiences of WWDs in accessing reproductive health care services in Bolgatanga Municipality. This discussion focused on the research objectives. It briefly described the basic demographic characteristics of respondents and centred on access to health care facilities and services, the attitudes of health care providers and other clients towards WWDs, health education/information and communication, and WWDs perceive society's attitudes about them accessing RHS.

5.1 Demographic characteristics of respondents.

The ages of the respondents ranged from 21- 45 years. The age group that accesses RHS most was 31 - 35 years. This implies that, respondents wit6hin the ranges of 31-35 years were most likely to be married or willing to have children hence the need for RHS like ANC, skill delivery or PNC RHS.

Also, with the marital status of the respondents, many of them were single and a few were divorced. The high proportion of single parents could make them vulnerable in society since there is no partner support. They may have inadequate support to health facility as their boyfriends may not want to be known to the public about their sexual relation. This is consistent with Nosek*et al.*, (2001), and Mavuso and Maharaj (2015) who observed that women with disabilities have less opportunities to create intimate or loving relationships. The high number of unmarried respondents might also be linked to WHO (2009) study that revealed that persons with disabilities have often been denied the right by family members and sometimes community members to create relationships and to decide regarding when to have a family and with whom. It is in the light of this that Article 23 of the United Nations Convention (2006) expects States/nations to get rid of discrimination against PWDs in respect to their relationships, marriage, family life, and childbearing, in addition to areas of fertility and planning family.

In view of occupational status of the respondents, most of the women were engaged in menial jobs like basket weaving, dress making, hair dressing, among others. Though many of the respondents have an income generating occupation, the annual incomes were woefully inadequate to meet their needs. This implies the respondents are exposed to financial challenges that could affect their health, transportation, and nutrition, among others. Though the government of Ghana also gives 3% of common fund to PWDs, there are delays in its disbursement. This finding is supported by Iezzoni *et al.*, 2013; and Steinmetz (2006), that women with disabilities often have fewer financial resources than their able peers have and therefore the financial burden of pregnancy, delivery, and childrearing may be high for this less privileged population.

The results on the educational status of the respondents showed that most of them have had formal education. This implies that parents are desirous of sending children with disabilities to school. Health education and health seeking behaviours will be quite good considering the level of education of the respondents. Low educational level of an individual has a relationship with low health literacy (Weiss, 2003; Rudd, 2007; Heide, et al., 2013)

With regard to the religion background of the respondents, most were Christians with few Muslim. The study revealed that there was no discrimination among WWDs seeking reproductive services on the basis of belonging to any of the two major religious groups mentioned above. The small representation of Muslim women in this study can be confirmed by the report of GSS (2012), which indicates that, there are more Christians in Bolgatanga municipality as well as in Ghana than Muslims.

Even though few of respondents have no children, majority had had one to four children. This finding is in line with that of Lezzoni *et al*., (2013); NCD, (2012) and Mitra *et al*., (2015) who observed that WWDs are increasingly deciding to have children or become mothers. It also shows that WWDs, like their counterparts are sexually active. It has been a misconception and false belief that PWDs are not sexually active, not interested in sex, or cannot take part in sexual activity (Nosek *et al*., 2007; Smeltzer *et al.*, 2010; and Trania, 2011). The WWDs in the Municipality are enjoying their basic right of reproduction as sited in WHO (2009), International Conference on Population and Development Programme of Action (ICPD PoA) that it is "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health'' (P5).

The findings of the study also pointed out that some of the respondents have had more pregnancies before but had fewer children. It is an indication that most of them might have lost their pregnancies or babies. This could also be attributed to the challenges in accessing RHS, such as transportation, finances among others and might have not been attending ANC during their pregnancy period.

Regarding the type of disability of the respondents, majority, 37.5% were WWPDs who either used wheelchair or crutches to aid in movement, whilst 33.3% were visually impaired (complete blindness) and 29.2% hearing and speech impaired individuals (complete deafness and dumb). The proportion of respondents with WWPD and visually impaired might have difficulties in walking to or within the health facility, whilst the hearing and speech impaired might need assistance in communication with health professionals when seeking services.

5.2 Access to Health Care Facilities and services

Access refers to one's ability to gain entry, admission, or right to use facilities. It is an essential variable in the utilization of health care services to all clients including WWDs. This could be physical accessibility, financial, and services/commodities accessibility. The availability or reliability of this access may have influence either direct or indirect in the utilization of the services.

The study observed that, all the respondents have ever accessed reproductive health care services in the Bolgatanga Municipality. Every one of the respondents has at least received services from ANC, PNC, FP, STIs, and/or delivery. These services received by WWDs in the municipality is in line with the comprehensive reproductive health care services of WHO. The core aspects of reproductive and sexual health are counselling, information, education, communication and clinical services in family planning; safe motherhood; gynaecological care; treatment and prevention of sexually transmitted diseases; prevention and management of sexual violence; active discouragement of harmful traditional practices such as female genital mutilation (WHO, 2006). The high patronage of these services might be due to their educational status and perhaps due to availability of RHS in the Municipality. This implies that WWDs also access all kinds of RHS available to them just as able women. The finding is in line with WHO (2009) recommendation that "persons with disabilities get the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and public health programmes". It is also supported by the finding of Mavuso and Maharaj (2015) that revealed that PWD get access to public health facilities for a variety of RHS, including STI treatment, HIV counselling and testing, and family planning contraceptives, among others.

The study also noted that most of the respondents have accessed public health facilities especially the Regional Hospital than private facilities in the Municipality. This could be largely due to the free ANC, deliveries, PNC, some FP services, and the use of NHIS in those facilities. The finding is also consistent with Oredola and Odusanya, (2017) that, patients prefer government facilities because of reduced cost and effectiveness of care while private facilities are preferred more notably because of short waiting time, good attitude of staff and perceived quality of care.

With regards to respondents' means of transport to and from health facility for reproductive services, it was revealed that most of them go there by foot. This means that RHS may be closer to some respondents and therefore does not require the use of vehicles for movement to the facility. A few of them use either motor bike or tricycle ("Mahama can do''). Though many of the respondents walk or use other means to reach health facilities, some of the respondents still have challenges with transportation to and from health facilities. Those who indicated having transport difficulties mentioned lack of helping hand (support) that makes movement difficult, inability to pay for cost involved if they have to take public means of transport (between one to seven Ghana cedis [Ghc1 and Ghc7] or more), and difficulties paddling the tricycle up the hills especially with pregnancy. In a FGD with WWPD, a woman stated that some drivers and tricycle ('Mahama can do'') riders feel reluctant to pick physically challenged persons because of the struggle they go through to enter the vehicle. They feel the passenger will waste their time or require some support to enter or get done from the vehicle. There is evidence that WWDs experience transportation difficulties that include problems getting into or out of a vehicle, drivers refusing to stop for them or to lift the wheelchair into and out of the truck, and long waiting time when using public transport to health facilities (Smeltzer *et al*., 2007). Some other passengers on board also grumble because they feel disturbed of space to accommodate these women and their walking sticks. In addition, some of the WWDs complained bitterly of the transportation cost to and from the health facilities especially if they have to send someone to help them. Mobility is a problem with women with disability as they could not move from their homes to the health care centres or facilities to receive reproductive health care especially those with sight problems, physical disability and those in rural areas (Ganle *et al*., 2016). It implies that WWDs may need personal equipment for mobility like tricycles or prostheses, personal assistance services, and financial assistance to be able to reach RHS centres. The finding is supported by Rugoho and Maphosa (2017) observation that PWDs who depend on personal aid for mobility incur more cost as they pay for two seats on public transport and sometime pays for the wheelchair, which makes it expensive for them to source reproductive health care. WHO and World Bank (2011) also observed that due to high level of poverty among this population, many of them are not capable of paying for means of transportation that will take them to these centres for services. In the event that means of transport is even available and affordable to client, the vehicles are not often easily accessible to those with physical disabilities to reach reproductive health centre. Study by Smeltzer *et al., (*2007) also observed that WWDs experience transportation difficulties including problems getting support into and out of a vehicle, refusal of drivers to stop for them or to lift the wheelchair into and out of the trunk when using public transport to health facilities.

At the health facility level, WWPDs also experience difficulties climbing the stairs and walking on slippery tiled floors. Focus group discussions with WWPDs and visually impaired persons, participants stressed that the floors of some facilities were so slippery because of the tiles. It makes walking difficult for them. Even those who are not disable are not spared stumbling to fall because of the slippery tiles. These challenges could influence WWDs in the municipality access to reproductive care negatively. Other studies also observed that the prime obstacle that WWPDs and visual impairment go through in accessing skilled care at the reproductive care facilities is the unfriendly nature of health care infrastructure (lack ramps, wheelchairs, and examination tables and delivery beds) (Smeltzer *et al.*, 2010; Ahumuza *et al*., 2014; Ganle *et al*., 2016).

Despite some attitudinal challenges, the WWDs had access to health care providers at the health facilities. All the respondents agreed that they had access to the key health care providers: Doctors, Physician Assistants, Nurses, and Midwives. This implies that health care providers are readily accessible to WWDs and they also have opportunity to receive the basic care and the specialist care from the various health professionals in the Municipality. This is in conformity with WHO (2009) who advocates that persons with disabilities get the same variety, quality and standard of free or affordable health care and programmes just as is given to other persons, including sexual and RHS and public health programmes. It is also in accordance to Rogers (2006), findings which notes that, group effort among different types of health care professionals (obstetricians, gynaecologists, nurses and midwives, among others), WWPDs and their social supports, are critical for helpful maternal care experiences. Many other researchers have also recommended that, multidisciplinary team of health care professionals check with the patient and her relations to develop a comprehensive formal written birth plan for safe delivery (Rogers, 2006; Rotheram and RNC Midwifery Society, 2007; Smeltzer and Sharts-Hopko, 2005). However, good communication and harmonization among these care providers is crucial to avoid unnecessary treatment, reduce harm, and promote quick recovery (Kuttai, 2010; Lipson and Rogers, 2000).

The respondents, however, have preferences to these categories of health care providers. Nurses and Midwives were the most preferred. They claimed the nurses and midwives educate them well and are also always available to them to access their services. The speech and hearing impaired women also said they understand a little bit of sign language that improves their communication.

The study observed that health care providers rendered reproductive care services to WWDs. It was clear from the study that most respondents have ever sought reproductive health service such as FP, ANC, PNC, and delivery services and have good knowledge on the basic benefits of RHS. According to them, those service centres are safer place to seek health care, receive proper care for both mother and baby, and obtain education on family planning and other reproductive related issues.

Some basic physical assessment was performed on most of the respondents during service delivery. The physical assessment such as palpation, and scanning were done during ANC. However, the respondents recognized abdominal palpation and scan as the only physical assessments. The participants do not see vital signs, weighing, history taking, inspection, and laboratory examination (urine, stool) which are routinely done in reproductive care services especially ANC as assessment. When there is no enough health information about good practices on reproductive health care, women will not know the procedures that comprise best care**.** This therefore makes it difficult or impossible for women to accurately assess their care if they are not familiar with what is considered good quality reproductive care (Baldisserotto et *al.*, 2016).

In this study, most of the respondents acknowledged availability of services/resources or commodities in the health facilities in the Municipality and also affirmed their satisfaction of the services. On the contrarily, a few respondents, disagreed and said the resources /commodities were not available and therefore, they were not satisfied as they have to buy drugs and other commodities from their pockets. This study had similar findings with Ganle *et al*., (2016) who discovered in their study that cost of maternal health care is not a serious challenge in Ghana because of the free maternal health care policy. This is in conformity with WHO (2009) whose findings state that accessibility also implies that medical resources such as family planning devices, medication and other commodities are available, affordable, and provided to PWDs in a more confidential, freewill, and respectful manner that every individual deserves. The lack of adequate care and medication results to some WWDs engaging in self-medication or visiting local herbalists as observed by Mulumba *et al*., 2014).

The study observed that WWDs pay some medical bills (services or drugs) even if they are insured with National Health Insurance Scheme. According to the respondents, they bear extra cost to receive health care services including reproductive care. The WWDs pay what they call “top up’’, meaning extra monies paid in addition to NHIS approved charges or fees on commodity or service like drugs, laboratory investigations among others if one is insured. Though many of the respondents claimed the service/resources/commodities are affordable, some described it as expensive. In all the FGDs, participants also noted that sometimes they pay for drugs or laboratory services even if you are health insured which are not easy for them. This has negative implications on health care access. Lack of funds to pay for health care services is most likely to lead to low accessibility and utilization of health care service by the client especially among persons with disability who generally have low income (Nguyen *et al*., 2015; Rugoho and Maphosa, 2017). In similar studies, Ahumuza *et al.*, (2014), and WHO and World Bank (2011), observed that lack of financial support and lack of health care insurance creates a barrier to persons living with disabilities to access health care including RHS. Other studies observed that WWDs have fewer financial resources than their able peers have and therefore have financial burden most especially during the periods of pregnancy, delivery, and childcare (Iezzoni *et al*., 2013; and Steinmetz, 2006).

The study further revealed that most respondents spent relatively short time at the reproductive health care facilities when they visit to seek health care services. However, few of the respondents claimed they stay long at the facilities when seeking RHS. Their delay was attributed to long queues and their inability to get to the next level on time (for example, laboratory, dispensary among others). Queueing for long at the health facilities has the tendency of discouraging persons living with disabilities from accessing health services (Alister, *et al.*, 2017). The delay may also discourage WWDs relatives or friends who assists them to the health facilities from going there subsequently. This could influence the WWDs to give up from accessing the reproductive services. One of the respondents indicated that at times they delay because health care providers attend to known relations before them. Some health care personnel favour their own friends and relatives when providing services at health facilities (Alister, *et al.*, 2017). Despite this, some still wish to visit those facilities subsequently because they are closer to them and have no option than to use them. On the other hand, some declined their decision to use the facilities subsequently and really changed to other public health facilities and private chemical shops to access RHS. Their preferences for other health facilities were not just to get quick services alone, but also to enjoy the available commodities/drugs. It therefore implies that availability of commodities/drugs, and quick service are key determinants of health care patronage by the client/patients. Long queues at the health facilities waiting to source service are the main challenges that persons living with disabilities face while trying to access SRH services (Ahumuza *et al*., 2014). Delays at health service delivery point causes patient/client dissatisfaction and failure to use the facility subsequently. Some clients may leave the health facilities without receiving the needed services or fail to come to the facility if the waiting time is long or when there are long queues (Sokhela *et al*., 2013). Patients also change health facility or prefer private facilities because of short waiting time and good attitude of staff just as it was also observed by (Oredola and Odusanya, 2017).

5.3 The attitudes of health care providers and other clients towards WWDs

Attitude of health care provider is an integral part of quality service delivery and utilization of the health facility by clients or patients. It is therefore expected that health care providers exhibit positive attitude in the discharge of their duties irrespective of the race, religion, or social status of the client/patient.

In this study, it was revealed that many health care providers showed positive attitude in their care for WWDs in Bolgatanga municipality. There was a mixed felling among participants regarding their experiences or interaction with health care providers.

Most of the respondents described them as friendly, approachable, polite, and supportive. It is an indication that some health professionals have good attitudes and sensitivity in handling their clients. However, some described their experiences with health care staff as unfriendly, discriminatory in the discharge of their duties because they serve known people first, impolite, get angry with them and sometimes even ignore them. Other study revealed mixed findings regarding WWDs perception of health care providers' attitudes towards them. As some of the WWDs express general positive experiences with health care providers, others do not (Devkota *et al.,* 2017).

Whereas some health care providers' attitudes are described as good, respectful, great among others, (Mitra, 2016), many are also described insensitive to the difficulties of women with disabilities (Ganle *et al*., 2016). Alister, *et al.,* (2017); and Bremer *et al*., (2017) also observed that most health care providers treat PWDs quite well whereas other health staff show poor attitudes towards them that serves as a barrier for accessing health services. In the FGDs with WWPDs and visually impaired women, some participants also expressed similar sentiment claiming that some health care providers behave like they fear them, or their disability is infectious and could infect them. According to them, some care providers do not want to handle or attend to them well. This could be viewed as poor attitude, lack of knowledge among some health professionals about how to handle WWDs or due to possible fears. This finding is consistent with other study which revealed that some health workers are inexperience to handle PWPDs or even fear them (Ahumuza *et al.,* 2014).

Though majority of respondents feel respected and dignified by care providers, other think they are not respected or given human dignity by some health personnel**.** They said some health care providers do not regard them as they are abused or scolded. These findings are not surprising because if able women were intimidated, scolded or abused while seeking reproductive health care (Yakong *et al.*, 2010; Alister, *et al.*, 2017; Ishola *et al.*, 2017), then what will happen to the WWDs who are marked with stigma and more vulnerable. Though WWDs are aware that all women including both with and without disabilities might be treated poorly, many perceived that their disability worsen this abuse from health care providers (Devkota *et al.*, 2017). Under no circumstance should WWDs be maltreated while seeking RHS as it was observed in the study. This finding also affirms Rugoho and Maphosa (2017) who observed that WWDs are insulted when they are pregnant and visit hospitals by mostly female nurses. The study finding supports some other studies that observed that it is common for WWPDs to experience negative reactions from family members and health care providers when they seek RHS or when pregnant (Powell, *et al.*, 2017; Andrews and Ayers, 2016; Tarasoff, 2015; Kuttai, 2010; Lipson and Rogers, 2000; Kallianes and Rubenfeld, 1997;). These negative attitudes of the health care providers have the tendency to cause harm to clients or reduce the utilization of RHS by WWDs. Gibson and Mykitiuk (2012), Lam *et al.,* (2010), and Smeltzer *et al*, (2010), noted that, if care providers exhibited negative attitudes towards women with disabilities, care may be inadequate and lead to situations that can cause harm to the client. Ahumuza *et al*., (2014), and Mulumba, *et al*., (2014) also concluded that unfavourable relations with health care staff coupled with negative approach and behaviours, insensitivity, and lack of knowledge, may lead PWDs to avoid seeking medical intervention or health promotion programs.

Persons living with disabilities equally have right to be respected and treated with dignity as they use services like any other persons which can also greatly increases their willingness to use the services subsequently. They have the right to reproduce responsibly without questions. Unfortunately, WWDs are sometime questioned of their right to reproduce or bear children. This implies that, the providers have little knowledge of handling WWDs, or they are insensitive to the women needs. This finding is also in line with Smeltzer (2007) and Tarasoff (2017) that revealed that WWPD were told out of inadequate knowledge by their health care providers that they cannot or should not conceive and have children because of their disability. It is common for WWDs to experience poor reactions from their family members and health care providers when they are pregnant (Powell, *et al.*, 2017; Andrews and Ayers, 2016). The study observation is also supported by other studies that revealed that in some cases health care providers denial, actively discouraged or abused WWDs for reproducing either due to doubts of their ability to care for the child or possible risk of child inheriting a hereditary condition which brings pain and anger on the women (Gibson and Mykitiuk, 2012; Maxwell *et al.*, 2007; Smeltzer, 2007). Meanwhile, WWDs are increasingly deciding to have children or become mothers (Lezzoni *et al.*, 2013; NCD, 2012; Mitra *et al.*, 2015). People living with disabilities are entitled to the right to decision making regarding their reproduction, free of discrimination, coercion, and violence, as clearly articulated in human rights documents (Glasier *et al.*, 2006).

Some acknowledged receiving support and protection from care providers. Most WWDs stated that they get assistance from some care providers. Some of the health care providers at times select WWDs from the queues and attend to them before other able persons that came before them. This is because there is an informal protocol at the health facilities to attend to PWDs as early as possible especially when they are pregnant. On the contrary, some care providers also fail to give them physical support and decline clients' request for assistance or support. The support is not universal to all of them as some of them have never received such assistance. They argued that the support is sometimes extended to able persons that care providers know, leaving them in waiting queues. In events where such support is given to WWDs, other clients do not agree. They usually complain bitterly when health care providers want to give WWDs preferential treatment (attend to them first) and behave unfriendly or rudely towards them. They have to queue with other able persons to get the service, which they considered not good enough. The struggle WWDs go through to compete with other able client for services could be attributed to lack of knowledge or insensitivity of the health care providers as observed by Ganle1 *et al.*, (2016). This is because by convention, the MOH has a protocol that permits persons with special needs to be attended to first, which include PWDs most especially when they are pregnant.

Visually impaired persons are sometime not supported adequately. Visual impaired persons require someone to lead them to health facilities. More often they go with a child who leads the way to the facility. Where there is absence of a child to help, it is not always likely for a community member to assist. They had difficulties finding or locating where the services were provided without support. Again, due to their impaired vision, at times other able persons jump the queue though it is their turn to see care provider to be attended to. In an interview with a visually impaired woman who has good anatomical structures of the eyes but lost vision, she expressed her frustration on how care provider shout at her when they ask her to carry out an activity at the health facility and she can’t do. The health care providers hardly identify her as a visually impaired person until they are prompted that she cannot see. This is an indication that health care personnel have difficulties or inadequate skills in identifying WWDs and their health needs as was observed by other studies (Ahumuza *et al.,* 2014; Taouk *et al.,*2018; Ganle *et al*., 2016). Persons with disability may need support to aid their movement and other physical activities especially at the health facility to avoid undue delay in receiving care. The finding gains roots from Alkawai and Alowayyed (2017) who observed that majority of clients with physical disability require some form of assistance because they cannot move around freely and independently in the health care facilities to access health care services and as a result are unsatisfied with the services receive. It also suggests that WWDs had inadequate family support, members of community and the health care staff during RHS as equally observed in Ganle *et al.*, (2016) and Powell *et al.*, (2017).

In addition, some able clients seeking same services at health facilities do not give WWDs support and look at them in a surprise manner as they struggle to access reproductive services. These findings are in consonance with other studies that revealed that persons with disabilities are often denied access to SRH services for many reasons, including stigma and discrimination, and lack of knowledge (Carol Thomas and Penny Curtis, 1997; WHO, 2009; and Mitra, 2016).

In some instances, the support from health care providers is so poor that the client feels abandoned especially when there are no words of support or reassurance from health care providers. For instance, a physically challenged woman in labour was left in the delivery room for a long time without examination or any word from midwives and others simply ignored and even insulted. Similarly, another woman mouth was covered with a pillow when she cried loud out of pain during labour by a midwife. Evidence revealed that WWDs, particularly those with severe functional impairments, do not receive the same quality of gynaecological health care as compared to their able counterparts (Nosek *et al.*, 2001). Persons living with disabilities may have special needs that should be identified, well understood by care provider, and given the needed technical care. Some health personnel are insensitive to the plight of women with disability and also lack the requisite knowledge about their needs and care (Ganle *et al.*, 2016). Another evidence proves that a lot of health care providers do not have knowledge regarding the dealings of pregnancy, labour/birth, and disability (Begley *et al.*, 2010; Lipson and Rogers, 2000; Nosek *et al.*, 2001; Rotheram and RNC Midwifery Society, 2007; Smeltzer, 2007).

Negative attitudes of health care providers towards women with disabilities influence the quality of care that they receive from care providers (Lam *et al.*, 2010). This finding is not strange to many WWDs. Evidence showed that some instances midwifery staff failed to see WWDs at the community level, claiming that the delivery process needs the help of a specialist, which is not really the case (WHO, 2009). They sometime view WWDs who are pregnant as liabilities and consider them as high risk and intensify their fears and anxiety (Walsh-Gallagher *et al.*, 2011; Tarasoff, 2017). The above findings are violation of UN (2006) rights of persons with disability. The convention recommends that health care should be provided to PWDs with equal verity, quality, standard, and free or affordable health care as provided to other able persons, including SRH. The action of the midwives could be viewed as negligence or insensitive to the plight of WWDs or both. There should not be any form of neglect or refusal to provide health care on the basis of disability. WWDs experience discrimination that has negative impact on their ability to access health services and medicines, and viewed it as a violation of the right to health, and other human rights breaches by health care workers (Mulumba *et al.*, 2014; WHO, 2009 and UN 2006). This poor attitude could retire these women from seeking reproductive health subsequently. Negative attitudes of health care providers towards WWDs makes it difficult for them to visit health facilities to solicit information and services on their reproductive health and sexual life (Rugoho and Maphosa, 2017).

In respect of WWDs' privacy in the health facilities in the municipality, an overwhelming majority of respondents acknowledged that health care providers maintain privacy during reproductive health care service delivery. Health care providers attend to them in private room and do not unnecessarily expose them. They also keep the WWDs' confidential information without sharing it with others who do not matter in their care. An environment that lucks privacy, the patients or clients will feel ashamed to express themselves freely (Maguire, 2000). The observation is in line with Article 22 of United Nations (2006), that calls for equal rights of PWDs to privacy during service delivery, as well as privacy of personal health information. The result also agrees with Mavuso and Maharaj (2015), that WWDs were satisfied with RHS because their personal needs and health information were kept confidential by health care providers. However, care provider in the municipality will require to maintain maximum privacy to all their clients. No single patient or client should be denied privacy at the health facility. The observation does not entirely disagree with Okafor, *et al.*, (2015) and Rugoho and Maphosa (2017) findings that health care providers offer non-confidential care, lack of privacy, and disclose sensitive patient information without their consent.

5.4 Health Education, Information and Communication

Health education, information and communication are key components of health care delivery system. The centre of all these components are grounded in communication. All the various areas of activities and interventions like prevention, treatment or therapy, rehabilitation, education, and health promotion greatly depend on effective communication. Information and explanations received during FP services, ANC, labour, and birth cares are important for quality and effective RHS delivery. If a woman is not educated or informed about her reproductive health needs including the progress of her pregnancy, labour and procedures that will be carried out, she is most likely not to participate in the decisions made by the health care providers.

From the study, health care providers provide the basic health education and information to WWDs in Bolgatanga Municipality. As a result of this, WWDs in the Municipality have basic knowledge on RHS and its benefits. All the respondents unanimously confirmed this in the study though with varying degree of satisfaction. They were educated on the benefits of the drugs/services received and their possible side effects. These include area of drugs (folic acid, iron supplements) during pregnancy, FP contraceptives, and the use of Insecticide Treated Bed Net during ANC and PNC. The WWDs are also educated on good nutrition, preparations towards delivery, and breastfeeding of their babies. Perhaps, the basic knowledge acquired by respondents with regard to reproductive health could be due to satisfactory health education offered at ANC, PNC or durbars organized by health service providers in the municipality. This finding is however contrary to WHO (2009) findings that revealed that PWDs do not gain even the very fundamental information concerning SRH and as a result they remain ignorant of basic facts.

According to respondents, the health educations and information are usually delivered clear, simple language, and understandable. However, in some instances, the presenter is not loud enough, and some care providers could not also communicate effectively to their understanding. This is most especially when the clients are many and they do mass education, those at the far ends do not hear them well. Communication can be enhanced during service delivery if care providers use non-technical language, frequency smiles and nods, good eye contact, and voice quality (Nicole, *et al.*, 2003). The care providers also use the appropriate language to the understanding of their clients. They often use the local language that is familiar to care receiver. The use of patients and clients' mother tongue in the delivery of health information is vital in promoting better patient-provider relationships (Nicole, *et al.*, 2003, Bernard, et al.,2006).

The providers are polite and friendly during health education sessions. Besides, health care providers spent ample time during health education sessions and also make the sessions interactive. The general impression of the health education and information delivery was impressive and satisfactory. Communication can improve patient and client's health outcomes as they are more likely to understand information if the providers communicate well. Engaging patients and clients in effective communication can lead to shared collaborations and decision-making processes. To improve interpersonal communication with patients, care provider should speak slowly and spend ample time with patient, limit the amount of information provided, and create an environment that is free from noise and shame (Weiss, 2003; WHO and World Bank, 2011).

It was also observed that health care providers educated WWDs on how to use FP devices and pills, other services, and asked questions for feed backs. The receivers were also given opportunity to ask questions to clarify misconceptions. These skills of impacting knowledge promote better understanding. Interpersonal communication with clients/patients can be good when care providers use plain language devoid of medical jargons, repeat information, and demand feedback, (Weiss, 2003).

Those who benefited most from the education were mainly the physically challenged persons because the speech and hearing impaired women could not communicate well with care providers or ask questions. The visually impaired women too could not see the commodities or pictures on flip chats to aid their understanding. This implies that the hearing and speech impaired are not always able to clarify misconceptions or even ask questions for better understanding. This finding consistent with article 21 of the UN (2006) that recommends that information meant for the public should equally reach PWDs in accessible designs and in technologies suitable to various kinds of disabilities at the right time without additional cost to them. To ensure that WWDs access quality health care, the client should have access to audible and visual alarm systems, qualified sign language interpreters, large printout of patient education materials and raised lettering and Braille (Mace, 2000).

The hearing and speech impaired women were dissatisfied of the medium of education or information delivery. Communication barrier was a major challenge they face when seeking care at the health facilities. This is because health care providers could not communicate effectively using sign language and the facilities too lack sign language interpreters. Hearing and speech impaired women are usually denied adequate information due to challenges in communicating in sign language (Roberts, 2006). They encounter difficulties communicating effectively with health care providers and also observed negative behaviour towards them from some of the health service providers. The health care providers feel hearing and speech impaired women are wasting their time as they do not understand each other during service delivery and get angry with the clients. Other care providers also laugh at them in their struggle to communicate with them. Sometimes health care personnel are impatient with hearing and speech impaired persons when they have communication challenges and ignore them (Alister *et al.*, 2017). The attitudes of health staff and physical problems create communication barriers among WWDs and health care providers which often makes the women described them as arrogant, disrespectful, or undermining (Smeltzer *et al.*, 2007). Sometime, at a critical point of need for care, they are still not understood by care providers. Those who can read and write are even better than their colleagues who cannot**.** As a result of their inability to verbally communicate, the health personnel do not understand their problems to give them better care. This implies that health care providers lack knowledge in dealing with or handling persons with speech and hearing impairment and show insensitive behaviours to women living with disabilities' plight. This was also observed in Ganle *et al.*, (2016) and Mitra (2016), that health care providers are insensitive to the difficulty of women with disability and also lack the requisite knowledge about their needs and care.

Speech and hearing impaired persons are usually denied adequate information due to care providers inability to communicate in sign language. This is in line with Mprah (2013) and Rugoho and Maphosa (2017) that observed that women with speech and hearing problems have little access to reproductive health information.

The skills and experience of health care professionals are not adequate to provide effective communication with people with hearing and speech impaired persons (Taouk, 2018). Health care providers could not take health history or educate women with speech and hearing impairment at health centres during RHS though the client could communicate using sign language as it was also observed by Mulumba *et al.*, (2014). The finding also strengthens the observation that medical staff in developing countries have very little or no training in sign language and therefore find it difficult to communicate effectively with speech and hearing impaired women during health service delivery (Margellos-Anast *et al.*, 2006). Unfortunately, there are no sign language interpreters at those health facilities, which make it extremely difficult for them to communicate effectively to health care staff during service delivery. Lack of information and communication materials, and lack of sign language interpreters serves as a barrier to person with disabilities to access reproductive health (WHO, 2009). The challenge might not just be a worry to only the speech and hearing impaired persons alone, but also to health care providers as well. It could be out of frustration and lack of knowledge that the care providers get angry of WWDs and sometime ignore them during RHS delivery. The provisions of services to the persons living with disabilities in health care settings create many challenges to health care providers with regards to how to communicate effectively with those with communication deficits (Smeltzer *et al*., 2010; and Ahumuza *et al.*, (2014).

Health care providers require special skills through professional training to deliver quality care to these WWDs according to their health needs. In the training of health professionals in Ghana, the curriculum does not significantly cover the care of persons with disabilities. This is evidenced by lack of sign language interpreters among health professionals in our health facilities to cater for the needs of speech and hearing impaired persons and materials to aid other categories of persons living with disabilities.

The health care providers also demonstrate some of the services such as FP pills and condom usage to WWDs just like the other able clients for better understanding during reproductive health education. Demonstration allows the client to see and practice how to use the product (drug, FP pills or device) practically or picture on the flip chat while running commentary alongside. Though the demonstrations are done for better understanding and practise, some of the respondents were dissatisfied claiming they were not enough.

The visually impaired could not also see to comprehend and appreciate the demonstrations. The women said the care providers normally put the device or item in their hands for them to feel it as they explain along to them but that is not enough to enhance their understanding. This finding too does not go in line with article 21 of the UN, (2006) that recommends that information be delivered to persons with disabilities in more accessible designs by using appropriate technologies such as use of braille, and all other accessible means to meet the client demand. Communicating health information in audio and picture design to the client; and demonstrating activities instead of just describing them, will improve better understanding of the education to the receiver (WHO and Word Bank, 2011).

The visually impaired women were not also quite happy of the mode of information delivery because they have no visual aids to enhance understanding. They did not also have information in graphic formats and material in large print or brail for those who could read for better understanding in any of the health facilities they visited. Lack of information and communication materials such as materials in Braille and large print, serves as a barrier to persons with visual impairments to access reproductive health (WHO, 2009). Similar other studies revealed that visually impaired persons have no access to information concerning sexual and reproductive health in different formats like braille, enlarged print or audio compact disks (Mavuso and Maharaj, 2015).

To deliver good health education, some materials or teaching aids are necessary to enhance better teaching and understanding. These materials in their rightful formats will be more helpful to persons with disabilities especially those with hearing, speech and visually impaired. The lack of information and communication equipment such as materials in Braille, large print, and pictures, could serves as a barrier to women with visual impairment and speech and hearing impaired to access reproductive health care services (Mace, 2000; WHO, 2009). In other to enhance understanding of health education or health information of speech and hearing impaired persons, picture format, demonstrating activities, sign language interpreting services, and readers are needed (WHO and World Bank, 2011).

5.5 The WWDs perceive society's attitudes about them accessing RHS.

Women with disabilities in Bolgatanga municipality have fairly positive perception of the attitude of the society about them accessing RHS. Whereas some WWDs have positive perception of some family members, health staff and society at large, other view them in the negative.

The respondents noted that there are no cultural beliefs or factors that impede their access to RHS. They said previously there was such beliefs, but it does no longer exist. The finding suggests that society is gradually getting understanding of issues of persons living with disabilities. According to respondents, they do not also receive any negative reaction from relatives. This observation was not consistent with finding of a study conducted by Mulumba *et al.*, (2014), which reported that most community and family members, and some health care workers see or treat PWDs as animals and attributed the discrimination they experience to be very much rooted in the culture. However, in FGD with WWPD, it was revealed that they are teased sometimes by friends and relatives in the form of jokes. WWDs are teased by some family members and friends when they are pregnant, but they are not worried about that. Though some family members and friends do say WWDs cannot give birth, cannot walk and yet want to have sex, have no sexual feeling, no man will love them therefore no need for family planning among others, the respondents viewed them as jokers. This teasing does not affect their access to service. Inadequate knowledge or stigma about disability leads to misconception and false believes that PWDs are not sexually active, nonsexual, have no interest in sex, or in capable of participating in sexual activity (Nosek and Simmons, 2007).

There is sufficient evidence that people with disabilities are sexually active like any other person and given the conducive environment they will seek RHS **(**Smeltzer *et al*., 2010; Trani, 2011**)**. Unfortunately, the society and some health care workers contribute to this menace by paying no attention to persons living with disabilities' sexuality and turn to view them as nonsexual. Women with disabilities gaining access to information regarding sexuality and obtaining reproductive care is difficult, as society often perceived them as nonsexual and have no need for this type of care (Piotrowski and Snell, 2007). It is therefore erroneous for one to assume that PWDs do not need sexual and reproductive services. Their inclusion in the reproductive health care will significantly help to achieve sustainable development goal three (3) that seeks to provide quality and equitable health care for all including reproductive health. They equally require the same SRH needs or care just like anyone else. Persons with disabilities may really have more needs for sexual and reproductive education and care as compare to able persons due to their disability and vulnerability to possible abuse (WHO, 2009).

The WWDs however, perceive society especially drivers/riders, some other able clients, and some health care providers not supportive enough to assist them get access or receive services at the health facilities. Persons living with disability per their inability to perform certain activities of human being should receive support and compassion from family and the society at large. Unfortunately, some WWDs do not get helping hand from family members to and from the facilities. The driver/riders also feel reluctant to support them enter vehicles or pick them. Some health care providers are also not willing to support them at the health facilities level to access service. This implies that there is luck of supportive care to WWDs. In other wise care that luck timely care, compassion, and caring manner to WWDs. Study revealed that PWDs perceived Ghanaian society as one without regard and respect for them in all aspect of life including, work, transportation, health, among others (Baffoe, 2013). It was observed that many women with disabilities perceived that the attitudes of health care providers and their understanding about disability and RHS were negative and discouraging (Devkota *et al.*, 2017).

Other studies have revealed that WWDs receive inadequate support from family, members of community, and the health care system during RHS perhaps due to negative perceptions society hold about disability and reproduction (Ganle *et al.*, 2016; Powell *et al.*, 2017). Further evidence suggest that some community members are not willing to assist persons with disabilities because of fear and stigma (Alister *et al.*, 2017).

Persons living with disabilities are capable of doing it all if only they are given the needed support. The challenges persons with disabilities face regarding reproductive health care are not necessarily due to the disability, but rather, it reveals lack of social support and understanding by the society on disability issues. The inadequate support bring hardship to the WWDs and affect their access to reproductive health care services.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.0 Introduction

The chapter summarizes the study and states the major finding in relation to research questions, recommendations based on the findings, limitations of the study and conclusions drawn from the findings of the study.

6.1 Summary

This study explored the experiences of women with disability in access reproductive health in Bolgatanga Municipality. Twenty participants were sampled from different categories of women with disability namely physically challenge, visually impaired, and hearing and speech impaired for the study. In-depth interviews were conducted using semi-structure interview guide to collect the data. The interviews were audio taped translated verbatim and analysed.

6.2 Conclusion

The conclusions of the study findings are that there is high patronage of RHS among WWDs in Bolgatanga Municipality with regard to ANC PNC, FP, STIs treatment, and delivery services. The study revealed that; though the health facilities are closer to most WWDs in the Municipality, some of them still have transportation challenges, which include some drivers and tricycle riders feeling reluctant to pick them as well as the cost of transportation to and from. This cost posed financial burden on some of the participants, which has implications for service utilization. It further indicated that WWDs were not able to access the health facility with ease when entering. The physically disabled persons have difficulties climbing the stairs and walking on the slippery tiled floor. The visually impaired persons also had difficulties locating where the services were provided in the reproductive units in the Municipality. Though WWDs in the Municipality get access to the key health care professionals when seeking reproductive health care, some do not receive the needed commodities in the health facilities because they are either not available or they cannot afford them. Lack of adequate commodities (FP, drugs, etc) in the health facilities in the Municipality result in some WWDs seeking herbal treatment or self-medication at chemical shops in the municipality.

It was Also observed that some health care providers and other able clients exhibited positive attitudes to WWDs as they showed respect, support and offered them privacy and confidentiality during reproductive health care in the health facilities in the Municipality. However, some health care providers and other able clients in the Municipality are not supportive. According to the women, some health care providers and other clients appear rude towards WWDs and abuse them verbally during RHS.

The study showed that health care providers give health education on reproductive health care issues to WWDs in Bolgatanga Municipality though with some challenges. WWDs also have good basic knowledge on the benefits of RHS in the Municipality. The kind of education given to them include good nutrition during pregnancy, preparations towards delivery, importance of intake of drugs such as folic acid, iron supplements during pregnancy, and how to use family planning pills and other devices, among others. However, the health facilities do not have graphic formats and material in large print or brail for visually impaired persons who could read to use for better understanding. Again, the speech and hearing impaired women in the Municipality face communication challenges as the health staff could not communicate in sign language and the facilities do not also have sign language interpreters.

Furthermore, the study showed that WWDs have fairly positive perceptions of society as they feel not discriminated but teased by family and friends. Besides, they perceive the society is not supportive enough for them to access reproductive care. They also think some health care providers feel their disability is infectious and do not want to handle them well during service delivery. However, the study found out that there were no cultural beliefs /factors that impede WWDs from accessing RHS in the Municipality.

6.3 Recommendations

The finding of the study revealed some challenge WWDs experience in accessing RHS in the Municipality. These include architectural challenges of the health facilities, negative attitudes of society and health care providers, communication barriers between heath care providers and WWDs among others. It is against the background of this findings that the study came out with the following recommendations.

1. The Health Facility Regulatory Agency (HeFRA) should ensure that as part of their monitoring of both public and private health facilities, the Ghana disability act 715 on building should be complied. The agency should also ensure that the facilities avoid the use of smooth tiles on the floor. These will compel service providers to modify the facilities structures and environment to suit PWDs.

2. As a result of negative attitudes such as denial of lift by drivers or tricycle rider, teasing or discriminations among others against WWDs accessing RHS, stakeholders including chiefs, assemble men, civil society and NGOs should advocate for behavioural change towards PWDs by giving them social support and compassion. This could be done through radio discussions and community durbars within the municipality and the region at large to enable them access services most especially RHS with ease.

3. Besides, as the study revealed that visually impaired women in the Municipality do not access health education or information with ease, the Ghana Health services (GHS) could design health information meant for education especially on RHS in graphic formats, braille or large prints and radio recordings for visually impaired persons who can read for better understanding.

4. GHS should organise and motivate health professionals to participate in in-service trainings on how to manage PWDs in the health facilities, code of ethics of the ministry, and treatment protocol to favour WWDs at the reproductive health facilities. In the long time, MOH should consider specialised training programmes of health personnel for the care of persons with disabilities. This will ensure that health

personnel are more abreast with health issues confronting PWDs and develop positive attitudes towards them to meet their health needs most especially the reproductive health.

5. The sign language course introduced in the Health Training Institutions should be strengthened (increase the duration from one to at least three semesters) by the Nurses and Midwives Council and the Principals of the colleges to enable nurses and midwives to communicate effectively with hearing and speech impaired persons. In the interim, MOH should recruit sign language interpreters at the service delivery points to ensure effective communication between health care providers and hearing and speech impaired women seeking reproductive health services.

6. GHS should ensure that WWDs should be attended to first before the able persons at the health facilities in line with the already existing conventions. Also, the service should formulate policy regarding this convention to enhance enforcement as a long-term measure.

7. Further studies could be conducted on the health personnel experiences in handling WWDs during RHS.

In conclusion, insight gained from this study show that WWDs go through physical and emotional challenges as they access RHS. The exploration of experiences of WWD in accessing reproductive health has provided an opportunity for participants to express their concerns that would help improve quality of health care delivery to women living with disabilities in future.

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APPENDIX

CONSENT FORM

Address: University for Development Studies,

Department of Public Health

School of Allied Health Sciences

Post Office Box TL1350, Tamale

Title of Research: THE EXPERIENCES OF WOMEN WITH DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES IN BOLGATANGA MUNICIPALITY

Investigator: Gnansin Mathias Nampar

TEL: 0244985546

E-mail: gnamparmathias@yahoo.com

General Information about the Research

The main objective of this research is to explore the experiences of WWDs in accessing reproductive health care in Bolgatanga Municipality. The study aims at exploring and coming up with vital information on experiences women with disabilities (WWDs) encounter in accessing sexual and reproductive health services in Bolgatanga Municipality. The individuals with disabilities go through physical and psychological experiences at service delivery points in our society.

Participant to be included in this study would be woman between 15-49 years of age who are physical challenge, visually impaired, and speech and hearing impaired and living within Bolga municipality for at least the past one year. If you consent to participate in the study, you will be interviewed and audiotaped. You will be interview at your own convenient time and place.

The interview session may last between 45minutes to 60 minutes. Personal data (age, marital status, occupation, level of education, religion, income and number of children) will be needed before the interview to enhance description of the findings.

Possible Risk and Discomfort

It is not envisaged that you would face any harm by participating in this study; however, you may face some psychological or emotional discomforts as you shared your experiences. You are at liberty to stop at any point in time if you so wish without any force. Also, if you become emotionally unstable in the course of the interview, it will be immediately suspended and rescheduled for another time if you so wish. In the event that you suffer severe emotional reaction, a counselor will be arranged to assist you at no cost to you.

Possible Benefit from the Study

The study may not directly benefit you as a participant, but the sharing of your experiences will significantly help in the better understanding of the challenges WWDs face when accessing sexual and reproductive Health services in Bolga Municipality. This will inform policy makers and service providers plan better care for PWDS.

Confidentiality

The participant is assured that any information you provide during interview session will be kept strictly confidential. The tape-recorded conversation will be strictly listened to and transcribed by me, my two supervisors and two local language translators. This tape will be kept under lock and destroyed after 3 years at the end of the study. Your name will not appear in any of the reports and where necessary, a number will be assigned to ensure your anonymity.

Compensation

There is no pay for participating in this study, however you will be refreshed or given a token after the interview.

Voluntary Participation and Right to Leave the Research

Your participation is voluntary and you have the right to decide on whether or not to participate in the study. You are at liberty to withdraw from the study at any point in time you wish without suffering any consequences.

Contact for Additional Information

If you have any question regarding the study, feel free to ask the investigator or the university. You can make enquiries about the study from

GnansinNampar Mathias

Tel: 0244985546

Email:gnamparmathias@yahoo.com.

Faculty Research Ethics Committee Office

School of Allied Health Sciences

Tamale Compus, Dungu

Volunteer Agreement

I acknowledge that the study on experiences of WWDs in accessing sexual and reproductive health care in Bolgatanga Municipality has been sufficiently explained to me including benefits, risk and the procedure of the study. I have been given an opportunity to clarify any question or concerns about the study to my satisfaction and I agreed to participate as a volunteer.

Name and signature/thumbprint of volunteer ………………………………………..

Date ……………………………………………………………………………………

If volunteers cannot read the form themselves, a witness must sign here.

I was present while benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research.

Name of witness ………………………………………………………………….

Signature/thumbprint ………………………………………………………………..

Date…………………………………………………………………………………

I certify that the nature and purpose, potential benefit and possible risk associated with participating in this research have been explained to the above individual

Name of person who obtained consent:…………………………………………...

Signature:………………………………………………………………………….

Date: ………………………………………………………………………………

DATA COLLECTION TOOLS

Interview Guide

Interview guide on investigating the experiences of women with disabilities in accessing reproductive health services in Bolgatanga Municipality

The researcher is a student of the University for Development Studies, pursuing Masters in Community Health and Development As part of the requirements for the award of the Master's degree; he is undertaking a research on the experiences of women with disabilities in accessing reproductive health services.

The information you provide on this interview guide will be kept strictly confidential and anonymous. NAME WILL NOT BE WRITTEN ON THIS SCRIPT. Also, you should be aware that by honestly and candidly completing this interview guide, you would be providing the researcher with valuable information to improve Sexual and Reproductive Health Services of persons with disabilities in Upper East Region. Participation is voluntary and you can decide to withdraw from the study at any point in time without any penalty. You are also allowed to skip a question if you are not comfortable answering it.

PLEASE ANSWERALL SECTIONS

Structured interview questionnaire

Demographic data

1. Age of respondent...
2. Marital status ……………………………………………..
3. Educational level ………………………………………………....................................
4. Occupation…………………………………………...

5. Average annual income……………………………………………………….
6. Religion………………………………………...
7. Number of children (if applicable)…………………………...............................
8. Number of pregnancies…………………………………………...............................
9. Type of disability...

MAIN QUESTION

Open-ended interview questionnaire

Access *(physical financial, service)*

1. Do you access reproductive care services? …………………….................................

   ANC………………..

   PNC………………...

   FP…………………..

   STIs treatment……..

   Delivery……………...

2. Have you ever been to any health facility or places where public health education is provided to access sexual and reproductive health care services? ....

   Probe: Where do you access these services (FP, ANC, PNC, Delivery,

   STIs Treatment)? …………………..

   If yes, which of the services did you go for? ....

3. How beneficial is reproductive health care services (FP, ANC, PNC, Delivery, STIs Treatment) to you at a point in time in your life? ....

4. By what means of transport do you take to the health facility? ……………………….......

5. Do you encounter difficulties with transportation to the health facility? ……………………..

Probe: kindly describe the difficulties in details if any ………………………………..

a. How much is the fair, if any ……………………………….............................

b. Will you describe the transport to be cost effective………………………..............

6. In your own opinion, what challenges do you face in accessing reproductive health service at the health facility?........... ....

a. When you got to the facility were you able to access it with ease……..……………

b. Please tell me how it was like for you getting into the facility…….............................

c. Were you able to see the service provider?…………………………..........................

d. Please describe your experience at the facility……………………..........................

7. Did you receive the needed services……………………………………….................

a. Did they carry out any physical assessment on you?...

b. Were the services /resources or commodities (e.g. drugs, contraceptives, delivery) readily available to you? ……………………………………...................................

c. Could you please explain how satisfied you were with the service…………………

8. What in your opinion do you think could be done better and how?……………………………..

9. Was the service insured, or cash payments? ……………………………................

Probe: How affordable was it to you? ……………………………….............

10. How will you describe the time you spend at the health facility? ……........................

a. Will you consider it as long, average or short time……………….............................

b. Does it influence your decision to source the service subsequently?............................

c. What exactly informs your decision? ....

11. Which other place(s) do you access reproductive health care services (ANC, PNC, FP, Delivery, STIs services? ....

Probe|:

a. What influence your decision to access the other place(s)?.................. ....

b. Tell me your experience in accessing services from those other places……..…......

Stigma

12. Are there some cultural beliefs or factors that make it difficult for you to access reproductive health care service?……………………….....................................

Probe:

a. kindly describe those beliefs /factors in details if any ……………………………..

13. What is usually the reaction from your relatives when you tell them that you are going to seek FP, ANC, PNC services or Treat STIs?..

Probe

a. Kindly describe how you feel about the way family member, friends and society treat you when you go to seek RHS?...

Attitude of health care providers/other clients

14. Tell me your experience with the health care providers or when accessing health care ……………………………………………………….............................

Probe:

a. How was your interaction with the nurses (friendly, not friendly, appeared approachable, not approachable)? ....

b. Describe your opinion in details……………………………………...........

15. Tell me your experience about what it is like to ask for help from health care providers at the health facility? ....

16. Who are the health care provider (s) available to you (doctors, PA staff nurses, community health nurses, health aids)……………………………………..............

Probe:

a. Which of them do you prefer?...

b. Why do you prefer the above mentioned health care provider?.................................

17. Do you feel that you were treated differently from other clients? ....

18. If you were treated differently, what will you attribute it to?.................................

a. Would you say the differential treatment was in your favour or discriminatory?..

b. Kindly tell me in details:…………………......................................

c. What was the reaction of other clients, (supportive and cordial or rude and unfriendly), describe in details: ....

19. Do you feel respected and dignified by the health care provider?............................

a. In which way?..

b. Was there any occasion when you felt you were not treated right?..................

c. what was the experience like?...

20. What would you say about the maintenance of your privacy during the time you were receiving the services……………………………...

Probe:

a. Sharing your confidential information to others who don't matter in your care………………......
b. Exposing you unnecessarily during physical examinations……..................................
c. Kindly tell me in details ....

Information and communication

21. Were you given education or information on the service you sought? Yes.....

No.............

If no skip to question 22

Probe:

a. Benefits of the service (eg FP, ANC, PNC, child delivery, treatment of STIs, counselling).....

b. Possible side effects of the services……………….……..

22. How would you describe the mode of communicating information to you?

....

Probe:

a. Were they audible and clear in their communication? ....
b. Simple and well understandable………………………..
c. Interactive and friendly……………………………...
d. Do you feel they were polite to you? ....
e. What was it like for you? ....

23. Do you think they spent enough time for you to understand the teaching?

....

24. As a hearing impaired person, were you satisfied with the medium of communication during the service (the use of hearing aids and sign language)?

……...

Probe:

a. What was your impression about the education given by the health care provider?..

25. As a visually impaired person, was the information presented simple, easily understood in graphic formats, materials in large print or Braille for easy comprehension? ....

26. Were you given opportunity to clarify issues for better understanding……..........................

27. Did the health care provider demonstrate activities such as pills or condom usage for better understanding instead of just describing them? ..………………........................

Probe:

a. Were you satisfied with the demonstration if any?…………………..................

b. Kindly explain in details……………………………………………................

28. What suggestion will you make to improve access of reproductive health services among women with disabilities in the region?.

……………………................................

Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE ON INVESTIGATING THE EXPERIENCES OF WOMEN WITH DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES IN BOLGATANGA MUNICIPALITY

The researcher is a student of the University for Development Studies, pursuing Masters in Community Health and Development. As part of the requirements for the award of the Master's degree, he is undertaking a research on the experiences of Women with Disabilities in accessing Reproductive Health Services.

The information you provide on this focus group discussion will be kept strictly confidential and anonymous. Also, you should be aware that by honestly and candidly contributing to this discussion, you would be providing the researcher with valuable information to improve Reproductive Health Services of persons with disabilities in Upper East Region. Participation is voluntary and you can decide to withdraw from the study at any point in time without any penalty.

PLEASE ANSWERALL SECTIONS

ACCESS (physical financial, service and cultural)

1. Do you access reproductive care services?:………………...............................

ANC…..

PNC...

FP……...

STIs treatment…..

Delivery……...

2. Have you ever been to any health facility or places where public health education is provided to access sexual and reproductive health care services? ....
3. How beneficial is reproductive health care services (FP, ANC, PNC, Delivery, STIs Treatment) to you at a point in time in your life? ....
4. By what means of transport do you take to the health facility? ....
5. Do you encounter difficulties with transportation to the health facility? ……………........

Probe:

a. Kindly describe the difficulties in details if any ……………………..........................

b. Will you describe the transport to be cost effective.…………………......................

6. In your own opinion, what challenges do you face in accessing reproductive health service at the health facility? ....

7. When you got to the facility were you able to access it with ease.……...………………......
8. Please tell me how it was like for you getting into the facility.…………...............................
9. Were you able to see the service provider?.………………………….........................
10. Did you receive the needed services? …………………………………........................

a. Did they carry out any physical assessment on you?..

b. Were the services /resources or commodities (e.g. drugs, contraceptives, delivery) readily available to you? …………………..

c. Could you please explain how satisfied you were with the service …………………

d. What in your opinion do you think could be done better and how?…..........................

11. Was the service insured, cash payments or top up payment with health insurance?

…………………………………………………………...

Probe: How affordable was it to you? …………………......................................

12. How will you describe the time you spend at the health facility? ……………........

a. Does it influence your decision to source the service subsequently? …………………

b. What exactly informs your decision? ....

13. Which other place (s) do you access reproductive health care services (ANC, PNC, FP, Delivery, STIs services?

....

Probe:

a. What influence your decision to access the other place (s)?..

b. Tell me your experience in accessing services from those other places……………………......

14. Are there some cultural beliefs or factors that make it difficult for you to access reproductive health care service?…………...

Probe: kindly describe those beliefs /factors in details if any ………………………

15. What is usually the reaction from your relatives when you tell them that you are going to seek FP, ANC, PNC services or Treat STIs?...

Probe

a. Kindly describe how you feel about the way family member, friends and society treat you when you go to seek RHS?..

Attitude of health care providers/other clients

16. Tell me your experience with the health care providers or when accessing health care

……………………………………………………..

Probe:

a. How was your interaction with the nurses (friendly, not friendly, appeared approachable, not approachable)? ....

17. Tell me your experience about what it is like to ask for help from health care providers at the health facility?...

18. Who are the health care provider(s) available to you (doctors, staff nurses, community health nurses, health aids)? ………………………...

Probe:

a. Which of them do you prefer?..

b. Why do you prefer the above mentioned health care provider?.......................................

19. Do you feel that you were treated differently from other clients? ....

Probe:

a. If you were treated differently, what will you attribute it to?...........................

b. Would you say the differential treatment was in your favour or discriminatory? ……………………………………………………...

c. Kindly tell me in details ....

d. What was the reaction of other clients, (supportive and cordial or rude and unfriendly), describe in details:..?

20. Do you feel respected and dignified by the health care provider?................................

Probe:

a. In which way?..

b. Was there any occasion when you felt you were not treated right? …………………......

c. what was the experience like?...

21. What would you say about the maintenance of your privacy during the time you were receiving the services? ....

Probe:

a. Sharing your confidential information to others who don't matter in your care…………………………………………………………….....

b. Exposing you unnecessarily during physical examinations……….................................

Information and communication

22. Were you given education or information on the service you sought? ....

Probe:

a. Benefits of the service (eg family planning, antenatal services) …..............................

b. Possible side effects of the services………………………….......................................

23. How would you describe the mode of communicating information to you?

....

24. Do you think they spent enough time for you to understand the teaching?..................

25. As a hearing impaired person, were you satisfied with the medium of communication during the service (the use of hearing aids and sign language)? ....

Probe:

a. What was your impression about the education given by the healthcare provider?

....

26. As a visually impaired person, was the information presented simple, easily understood in graphic formats, materials in large print or Braille for easy comprehension?...

27. Were you given opportunity to clarify issues for better understanding?

………………..

28. Did the health care provider demonstrate activities such as condom usage for better understanding instead of just describing them? ....……………....................

Probe:

were you satisfied with the demonstration if any?:…...

29. What suggestion will you make to improve access of reproductive health services among women with disabilities in the region? …………………..................................

THANK YOU FOR YOUR CO-OPERATION

UNIVERSITY FOR DEVELOMENT STUDIES
SCHOOL OF ALLIED HEALTH SCIENCES
DEPARTMENT OF PUBLIC HEALTH

The President
Disable Association
Upper East Region.

29/05/2018

Dear Sir / Madam.

LETTER OF INTRODUCTION FOR MR. GNANSIN MATHIAS NAMPAR

It is my pleasure to submit to you this letter of introduction for Mr. Gnansin Mathias Nampar a final year MPhil Community Health and Development (MCHAD) student, with Index number (UDS/CHD/0067/12) of the Department of Public Health, School of Allied Health Sciences.

Mr.Gnansin needs your support and permission to gather data for his thesis titled "Investigating the experiences of woman with disabilities in accessing reproductive health services in the Bolgatanga Municipality.

I therefore humbly recommend him for your utmost consideration and support. Should you have any clarifications or questions concerning this letter, please do not hesitate to contact me at your earliest convenience.

Yours Sincerely,

Head of Department
Department of Public Health
School of Allied Health Sciences
Univ for Development Studies
Tamale

Michael Wombeogo (PhD)
(Senior Lecturer & Head of Department, Public Health, SAHS/UDS)

GFD Ghana Federation of Disability Organisations
Upper East Region

Bankers:
GCB, Bolgatanga Branch

Our ref: gfdue/Vol/20/01 Your ref:

Date: 11th June, 2018

Michael Wombeogo (PhD)
Senior Lecturer & Head of Department,
University for Development Studies
School of Allied Health Sciences
Department of Public Health

LETTER OF APPROVAL

inform you that approval has been given to Mr. Gnansin Mathias Nampar to gather data from Women
bilities in the Bolgatanga Municipality per your request in a letter dated 29th May, 2018. We will offer
eeded assistance as may be required. We would also be grateful if you could give us the feedback of the
f the study.

cerely

GHANA FEDERATION OF
DISABILITY ORGANIZATION
P. O. BOX 445,
BOLGATANGA - UE

iah Awine
President
derations of Disability Organizations
st Region
a.