ORIGINAL RESEARCH ARTICLE

Barriers to utilization of sexual and reproductive health services among young deaf persons in Ghana

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Wisdom K. Mprah[1], Juventus Duorinaah[2], Maxwell P. Opoku[3] and William Nketsia[4]*

Centre for Disability and Rehabilitation Studies, Department of Health Promotion and Disability Studies Kwame Nkrumah University of Science and Technology, Kumasi, Ghana[1]; Ghana National Association of the Deaf, Accra-Ghana[2]; Special Education Department, United Arab Emirates University, Al-Ain, United Arab Emirates[3]; School of Education Western Sydney University, Sydney, Australia[4]

***For Correspondence:** Email: *Maxwell.p@uaeu.ac.ae*; Phone: +971 (0)37136268

Abstract

Despite significant progress made to improve access to sexual and reproductive health (SRH) services to the general populace in Ghana, information on the accessibility of such services to deaf persons is limited. This study investigated access to and utilization of SRH services among young female deaf persons in Ghana. Sixty deaf persons were interviewed from six metropolis/municipalities/districts in three regions of Ghana. The data were collected using focus group discussion and one-on-one interviews. The data were subjected to content analysis, leading to the identification of two broad themes. The study identified barriers at two levels: point of service delivery and barriers at the individual level. For instance, at the point of service delivery, they were claims that deaf women were victims of negative attitudes from health workers. The study concludes on the need for health policymakers to consider collaborating with the Ghana National Association of the Deaf in an effort towards designing inclusive SRH programmes. *(Afr J Reprod Health 2022; 26[12]: 58-66).*

Keywords: Access, deaf people, sexual and reproductive health, policies, utilization

Résumé

Malgré des progrès significatifs réalisés pour améliorer l'accès aux services de santé sexuelle et reproductive (SSR) pour la population générale au Ghana, les informations sur l'accessibilité de ces services aux personnes sourdes sont limitées. Cette étude a examiné l'accès et l'utilisation des services de SSR chez les jeunes femmes sourdes au Ghana. Soixante personnes sourdes ont été interrogées dans six métropoles/municipalités/districts dans trois régions du Ghana. Les données ont été recueillies à l'aide de discussions de groupe et d'entretiens individuels. Les données ont fait l'objet d'une analyse de contenu qui a conduit à l'identification de deux grands thèmes. L'étude a identifié des obstacles à deux niveaux : le point de prestation de services et les obstacles au niveau individuel. Par exemple, au point de prestation de services, il y avait des allégations selon lesquelles les femmes sourdes étaient victimes d'attitudes négatives de la part des agents de santé. L'étude conclut sur la nécessité pour les décideurs de la santé d'envisager de collaborer avec l'Association nationale des sourds du Ghana dans le but de concevoir des programmes de SSR inclusifs. *(Afr J Reprod Health 2022; 26[12]: 58-66).*

Mots-clés: Accès, personnes sourdes, santé sexuelle et reproductive, politiques, utilisation

Introduction

Since the United Nations International Conference on Population and Development (ICPD), there has been growing interests on Sexual and Reproductive Health (SRH) issues, especially among underserved populations[1,2]. The ICPD's Program of Action presented a paradigm shift on SRH issues, and this led to emphasis on social, political, cultural, and legal factors, which influence SRH outcomes[2]. This has resulted in increased attention towards right-based policies, laws, and approaches to addressing challenges to access to SRH services[3,4]. One area that has received much attention is the SRH needs of vulnerable groups such adolescents in SRH policies and programmes. Adolescents have the tendency to engage in risk SRH behaviour, such as unprotected sex and unsafe abortions[5,6]. For example, studies in Ethiopia,[7] Nigeria[8] and Ghana[9] have confirmed that adolescents have unmet needs for SRH services. However, their needs are often inadequately captured in SRH policies and

programmes[5,6]. In light of these discussions, the SRH needs of the youth who are deaf are yet to be mainstreamed in public discourse.

In Ghana, effort towards promoting access to SRH services began in 1969 where a national policy was developed to address the high population growth rate and its consequence on the socio-economic development of Ghana[10]. The policy was revised in 1994 and its scope was expanded to include vulnerable populations such as the aged and people with disabilities. The policy recommended that appropriate measures should be taken to ensure that underserved population were effectively integrate into society[10]. Following the national population policy, several policies on SRH were formulated to address the specific needs of subgroups who are unlikely to benefit from SRH policies for the general population. Some of these policies include the Reproductive Health Service Policy and Standards[11,12], the Adolescents Reproductive Health Policy[6], and the National HIV/AIDS and STI Policy[13].

In Ghana and similar contexts, deafness is traditionally understood as a sin or punishment handed down to parents for offending their ancestors14-17. At the family level, there is little effort made to support the deaf children to access basic services such as education18. In the society, access to essential services are usually restricted to deaf persons. Due to the cultural stereotype, limited efforts are made to include them in social services in the society19. In terms of education, there are inadequate learning facilities available to deaf persons. They also face barriers when it comes to participating in healthcare, employment and even leisure19-23. There is some acknowledgement of these barriers and both the national government and international development partners have provided guidelines to enhance their living conditions in societies.

Despite efforts being made to improve access to SRH to person with disabilities worldwide, evidence has shown that they generally face serious challenges accessing SRH services[24-28]. Specifically, SRH services are not reaching people with disabilities because they are not customized to meet their needs. The situation is worse in countries in the global South. In a qualitative study on SRH and rights for women with disabilities in rural Cambodia found that women with disabilities have very little knowledge about SRH issues compared to women without disabilities[29]. One other key finding in the study was that although family conversation on SRH was a primary source of information on SRH issues, women with disabilities were less likely to benefit from this source. In a report on public inquiry into violations of SRH rights, the Kenyan National Commission on Human Rights[30] noted that persons with disabilities suffered myriad of SRH rights violations. The inquiry identified discrimination and stigma, difficulty in accessing health facilities due to infrastructural barriers, high cost of services, and difficulties in accessing information as some of the key challenges. In Indonesia, a qualitative study was conducted to understand the needs and extent of accessibility of SRH to deaf adolescents. The finding showed limited knowledge as well as lack of training opportunities.[31] In the Ghanaian context, persons with disabilities have not been adequately targeted in SRH research in Ghana. In fact, the few studies available have revealed that persons with disabilities are not benefiting from SRH programmes designed for the general population[20,31-34]. Unfortunately, studies focusing on access to SRH services to young deaf women is very rare and as such, the need for the study reported here.

The rights of persons with disabilities to the highest attainable standard of SRH has long been recognized[28]. The ICPD, for example, recognized the right of people with disabilities to SRH as integral part of their human rights. The ICPD Program of Action enjoined state to create awareness about the SRH needs of persons with disabilities and to facilitate their full participation in SRH decision making. This right is re-echoed in Article 25(a) of the United Nations Convention on the Rights of Persons with Disabilities[35]. The UNCRPD reaffirmed the rights of persons with disabilities to achieve quality SRH live. In Ghana, the disability act has made provision for accessible healthcare services to persons with disabilities. However, in the face of these legal framework, access to SRH seemed to be farfetched for young deaf women. To respond to the SRH needs of deaf women and girls, a clear understanding of the barriers hindering access to and use of SRH services, from the perspective of deaf women and girls, is needed. This called for this study. The study

was undertaken to increase the utilization of SRH services among deaf women and girls in Ghana. The specific objectives of the study were to examine the level of knowledge and factors that affect the accessibility and utilization of SRH services among deaf women in Ghana.

Methods

The study was carried out in six districts three out of the 16 administrative regions in Ghana. The districts were Savelugu Municipal and Tamale Metropolitan both in the Northern Region, Sunyani Municipality and Tano South District in the Brong Ahafo Region, and Accra and Ashaiman in the Great Accra Region.

Sixty deaf persons were recruited for this study. They were made up of 10 participants purposively selected from each district (seven for focus group discussions (FGDs) and three for interviews). It means that for each study area, we conducted one FGD made up of seven young deaf persons and interview with three adults[10]. All the focus group participants were females (42), whiles the interview participants were males (18) (see Table 1). We included deaf males because of intermarriage between deaf persons, making deaf males, important stakeholders when it comes to issues pertaining to SRH.

A desk review of seven documents on SRH was conducted to examine if and how they have included disability issues. The seven documents that were reviewed are: the Ghana Demographic and Health Survey 2014, Ghana Population Policy, Adolescents Reproductive Health Policy, National HIV/AIDS and STD/STI Policy, the Criminal Offences Act, 1960, Ghana Maternal Health Survey Report, 2017 and Management and Prevention of Unsafe Abortion: Comprehensive Abortion Care Services Standards and Protocol. Following this, focus group discussion and face-to-face interviews were conducted to gather primary data from deaf persons. A semi-structured interview guide was used for data collection. The questions on the interview guide was developed from review of literature[1,3,7-10]. The questions covered two broad areas: experiences and barriers to accessing SRH services.

Approval was sought from the Committee on Human Research and Publication of X before the study was implemented. Informed consent was obtained from all participants before they were recruited into the study. Six field assistants were recruited to assist with the data collection. All the field assistants are deaf persons and had at least a first degree or diploma at the time they were recruited. The position of the field assistant was advertised by Ghana National Association of the Deaf (GNAD) and qualified persons were selected and given a brief training on how to conduct focus group discussions (FGDs), interviews and administer questionnaires. They were also trained on ethics of conducting research –voluntary recruitment of study participants, and respecting participants' privacy and confidentiality.

Erlingsson and Brysiewicz[36] approach to content analysis guided the data analysis. The approach consists of six steps: familiarizing with the data, dividing the text into meaning units, condensing meaning units, formulating codes, developing categories, and developing themes. The research

Table 1: Demographic characteristics of study participants

Categories	Sample (N = 60)	%
Mode of participation		
Focus group	42	70%
One-on-one interview	18	30%
Gender		
Male	18	30%
Female	42	70%
Age		
18–25 years	33	55%
26–35 years	10	17%
36–45 years	11	18%
46 years and older	6	10%
Religion		
Christian	34	57%
Muslims	22	36%
Other	4	7%
Educational level		
Primary level	31	52%
High school level	16	27%
Tertiary qualification	13	22%
Employment		
None	26	43%
Student	5	8%
Self-employed	19	32%
Public service	10	17%
Marital Status		
Single	26	43%
Married	29	48%
Divorced	5	8%

***participants were above 18 years*

assistants transcribed the video recordings into word format. The transcribed information was then read through several times by the research team to understand the text, ensure accuracy, consistency, and to edit for grammatical errors. Several notes were made during the viewing and reading of the transcripts. The next stage, the dividing up stage, involved splitting the text into meaning units using our research questions as a guide. The meaning units identified in each transcript were then condensed, whiles ensuring that the essential ideas were still retained. Afterwards, the authors continued to code all the condensed meaning units using alphabets. The next stage involved sorting out similar codes (codes that dealt with the same issue) and pulling them together into categories. From the categories, we developed themes by grouping a number of categories. Two overarching themes were developed: (a) barriers at the point of services delivery and (b) barriers at the individual levels. For instance, barriers at the point of service delivery has three subthemes: communication barriers, barrier associated with cost of health care, and attitudinal barriers. Additionally, barriers at the individual level entails the capacity of deaf persons to assert for SRH services.

Results

The document review indicated that attention given to disability, and for that matter, deaf people in the seven documents was minimal. Apart from the Ghana Maternal Health Survey, which has disaggregated data on disability and explored how disability influenced access to maternal health services, all the other documents either did not have anything on disability or the attention given to disability was minimal. For example, the National HIV/STI Policy and the GDHS did not have anything on disability. Although the Population Policy and the Adolescent Reproductive Health Policy have some provisions focusing on persons with disabilities, these provisions were inadequate to address their SRH needs. Indeed, interviews showed the following barriers: (a) barriers at point of services delivery and (b) barriers at the individual levels.

Barriers at the point of service delivery

Communication barriers

From the responses, participants knew of organizations that provide services on SRH and had visited some these organizations to access services on SRH issues. Among the organizations mentioned were Planned Parenthood Association of Ghana (PPAG) and public healthcare clinics. But participants were frustrated by communication barriers, which some said could lead to misinformation among deaf young females.

"Deaf women and girls are not educated or helped to understand SRH issues. They have to use their own thinking to follow pictures and improvised demonstrations by health workers. Without interpreters, we cannot access information and services on SRH issues, and this can lead to guesses and wrong information that cause problems for deaf girls. (Deaf Female Participant 1, FGD 1)".

Some of male participants also expressed the same frustrations with the services they received at the healthcare centres. From the above, it could be seen that the presence of sign language interpreters is critical in ensuring effective communication between deaf people and SRH service providers. The lack of this service has created barriers to and dissatisfaction with information received by female deaf youth seeking SRH services.

Barriers associated with cost of health care

Cost of healthcare can be a deterrent to services users. In the current study, more than 90% of the participants in the FGDs admitted that cost of accessing SRH services was high for them given their level income. Two forms of costs were identified: payment of services such as drugs and payment for sign language interpretation services. A female participant lamenting about the cost of SRH services, said that, "Yes, I know it [safe abortion] and I desired to do safe abortion, but financial problems, and abortion cost is very expensive, but we young deaf people mostly do not work" (Deaf female participant 16, FGD 3). Another FGDs participant remarked:

They [deaf women and girls] are aware but they do not have money to visit the hospitals because it is expensive. Many deaf girls do not have jobs to get money for SRH services. Also, the men who made them pregnant do not care. Since they are not able to afford to go to the hospital, the use the wrong methods. But if the cost of abortion is low, many young people can afford to do it." (Deaf male participant 3, interview 3)

A male participant concurred with above and stated that:

We are aware of such methods [abortion prevention methods] but some do have difficulty attending health centres where the services are provided for advice because of the cost to pay for interpreters and buy medicine is too much. Interpretation service alone is high and deaf women and girls, without jobs cannot afford this (Deaf male participant 2, interview 2).

Attitudinal barriers

Negative attitude of health workers at the various facilities towards deaf people emerged as a disabling factor that affected the utilization of SRH services among young deaf persons.

In the FGDs, for example, participants complained about how attitude of healthcare workers made it difficult for female deaf persons to access SRH information and services. "…whenever I attend hospital for screening, the workers do not show a single bit of respect towards me. The attitude of nurses thus forced some deaf people to go for self–medications" (Deaf female participant 22, FGD from 4). An interview participant also said:

Yes! Because of their attitude, the lectures they give us on our reproductive health seem boring without the use of pictures and images to arouse viewers' interests. Most of the healthcare workers do not also pay attention and are rude to deaf patients who seek assistance at the SRH centres, and this creates barriers for us. (Deaf male participant 6, interview 6).

It should be noted that even without interpreters, positive of health care providers can go a long way to increase use of SRH services. The challenges at service point have caused many young female deaf persons to be dissatisfied with the services they received. In fact, all the participants in the FGDs were not satisfied with the services they received from healthcare providers.

Barriers at the individual level

These barriers originated from deaf persons but not necessarily caused by them or their deafness. Some of the participants were of the view that deaf people lacked knowledge of their rights to SRH information and services. As a result, they did not demand for these services. For example, some of them thought that because hearing people were aware of their rights to SRH services, they demanded for the services. Consequently, the hearing population has more access to more information on SRH issues than the deaf population.

"The hearing population know more about their rights to information and services on SRH, they are encouraged to ask for more information and services on SRH related matters. Deaf people cannot do this because they are ignorant of their rights (Deaf male participant 14, interview 14)".

Another barrier at the individual level was the inability of deaf people to read and write, as shown in the following quote: "They [deaf people] become less and less uninformed because of the difficulty to read" (Deaf male participant 7, interview 7). A FGDs participant from Tamale supported this claim and said that, "deaf people cannot read and write and so they do not understand information in written papers." This is particularly true because "health information is complex and one needs higher education to understand it but deaf people, in general, have low education" (Deaf Female participant 2, FGD 1). A participant in the FGDs from Tamale commented.

"Some of us never went to school before and as such could not sign and write well. Therefore, it becomes a problem when we are inquiring for information and services on any of the SRH services from health workers because of lack of sign language interpreters".

The consequence of barriers to quality SRH information and services is inadequate knowledge among young deaf females. One participant highlighted on this issue in the remarks below.

Deaf people are always ignorant and that easily get them pregnant, and they sometimes try to abort and

get sick or die from STDs. Some deaf people show side effects of the drugs they used without doctors' prescriptions and those who have unsafe abortion have health complications after that, which can easily lead to death because the deaf do not know (Deaf Female participant 38, FGD 7).

Discussion

This study examined barriers to the utilization of SRH services among young female deaf persons in Ghana. The study revealed myriad of barriers hindering access to and the effective use of SRH services by this population. At both service delivery and individual levels, there were challenges which had impact on access to SRH to deaf persons. For instance, access to information is an important component of decision-making. The availability of reliable information in accessible formats, helps people to make informed decisions and choices[37]. The findings however indicated that participants in our study encountered communication barriers, making it difficult for them to access SRH information and services from health care professionals. Adolescents and youth, especially, require reliable information on SRH matters and strategies implemented to increase their utilization of the information. This is because adolescents have the tendency to engage in risky behaviors that could expose them to SRH problems. They are also unlikely to benefit from SRH programs for the general population[6]. According to Woog and Kagesten[38], the adolescence stage is one of the most important periods to lay the foundation for positive SRH outcomes. During this period, many young girls and boys are likely to practice unsafe sex and die through pregnancy related complications such as unsafe abortions. Providing quality SRH related information and support at this stage is important for improving their SRH behaviour and overall wellbeing[38]. The result underscores the need for health policymakers to provide accessible SRH information to deaf persons to enable them protect themselves.

In Ghana and similar contexts, there is evidence that disability is intricately linked to poverty[19,20]. In this study, the findings showed that the poverty restricted the ability of young deaf women to access SRH services. In relation to deaf persons, they lack income to access essential services because of inaccessible education which them the chance to access jobs. Unfortunately, the health policymakers seemed to have not considered this barrier in their effort to extend SRH services to all. Thus, the social support system for persons with disabilities is very weak. In view of this, deaf persons struggle to make a living and access services[19]. It is essential for policymakers to consider providing free SRH services to deaf persons. In doing this, they would be able to enjoy their reproductive rights without any restriction.

Individual knowledge and awareness of the availability of SRH services and their rights to demand for the services are vital to utilization of the services. But as the findings of study showed, although participants acknowledged that knowledge of one's rights to information and services on SRH was important, they did not possess it. The lack of knowledge on their rights is possibly due to the high illiteracy rates among deaf people in Ghana. The low literacy among deaf people and its consequences on utilizing SRH services has been identified by some studies on deaf people in Ghana[32,33]. Schiavo[39] also identified educational attainment as one of the important factors influencing utilization of health information. Going forward, health policymakers could provide workshops for deaf persons to enable them to be aware of their health rights and adopt safe SRH practices.

The findings indicating that healthcare providers have negative attitude towards deaf people seeking SRH services is consistent with previous studies[32-34]. These studies revealed that ignorant and negative attitude on the part of health care workers did not only reduce the quality of services provided, but also discouraged deaf people from seeking SRH services. It is important to note that negative attitude may not be manifested only against deaf people but could be a general issue affecting some groups of people when accessing SRH services. In a study conducted by Abuosi and Anaba[40] on barriers to access to and use of health services in Ghana, the authors found that health care workers' judgemental attitude towards adolescents discouraged them from seeking SRH services. As part of effort towards changing the attitudes health workers, they could be educated about the

characteristics, acceptance, sign language training and appropriate ways they could work with deaf persons.

Conclusion and implication for policy

The findings of the study ought to be interpreted with caution due to some limitations. The study drew on participates from three out of the 16 regions in Ghana and thus, impossible to generalise the findings of the study. The participants of the study were all members of Ghana National Association of Deaf. In view of this, deaf persons who are not members of the GNAD were not considered for this study. Future study will expand this study further by comparing experiences of non-members and other disability groups. The study has shown barriers to SRH services at both point of service and individual levels. This situation has the potential to make it difficult for young female deaf persons to exercise their sexual rights which could derail efforts at reducing SRH problems. The findings from this study have brought to the fore the complexity of the Ghanaian population and point to the need for health policies, in general, to be designed in a way that people with diverse needs and preferences can access and use. The findings point to the need for interventions aimed at improving knowledge and awareness among deaf people about their SRH rights. However, any intervention for the deaf community will only be effective if it is based on collaboration with the GNAD. The need to train health professionals in the use of sign language and financial support to deaf person is highly recommended.

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Conflict of interest

The authors declare no conflict of interest.

Ethical approval

The Ethics and Publication Review Board at the Kwame Nkrumah University of Science and Technology reviewed and approved this study (CHRPE/AP/375/16). The Institutional Review Committee at Ghana Health Service approved the study and its protocols. All participants signed or thumb printed on the informed consent form before participating in this study.

Authors contributions

WKM, DV and MPO conceived and designed the study, conducted research, provided research materials, and collected and organized data. WN analyzed and interpreted data. MPO and WN wrote initial and final draft of article. All authors have critically reviewed and approved the final draft and are responsible for the content and similarity index of the manuscript.

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