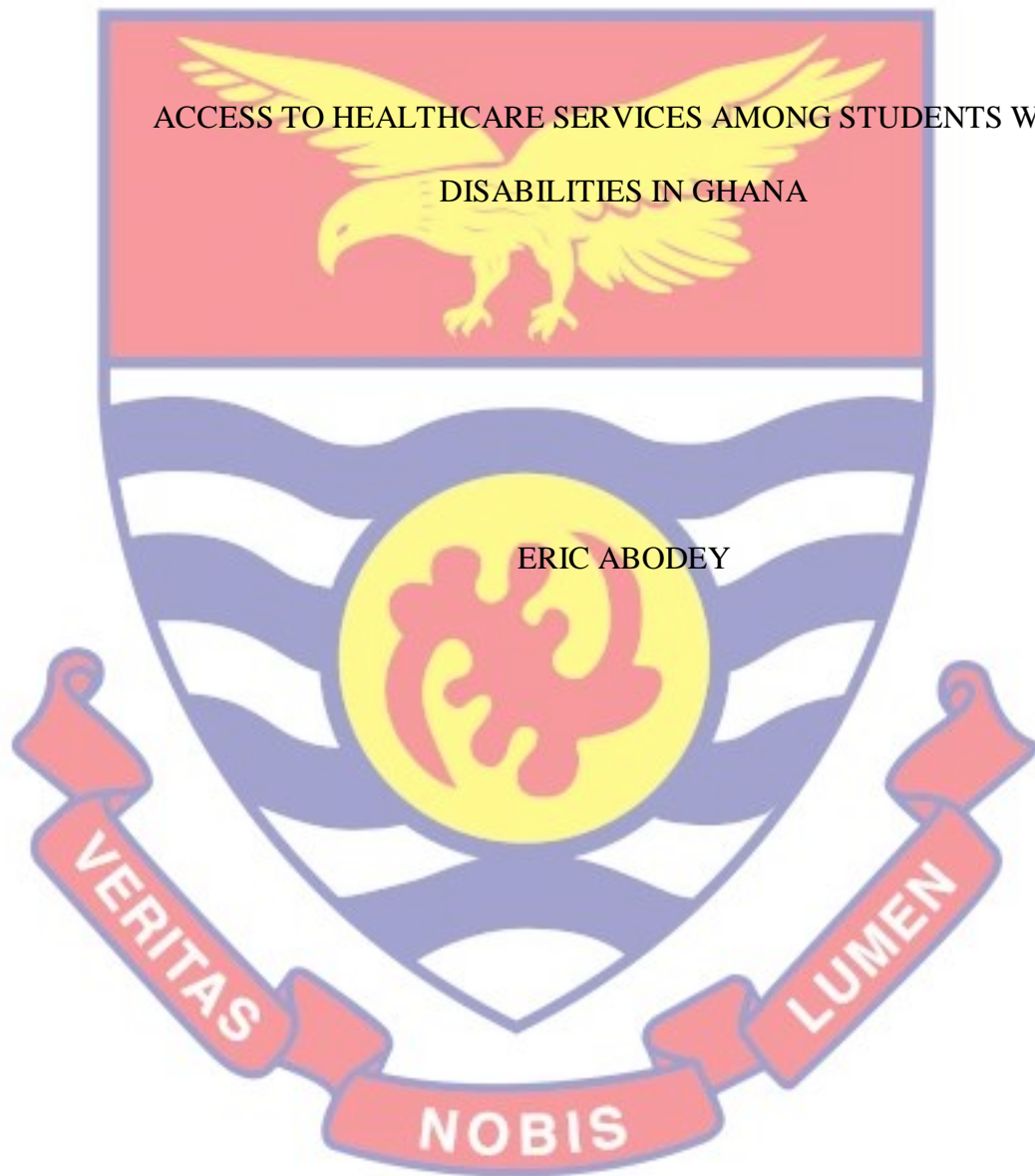


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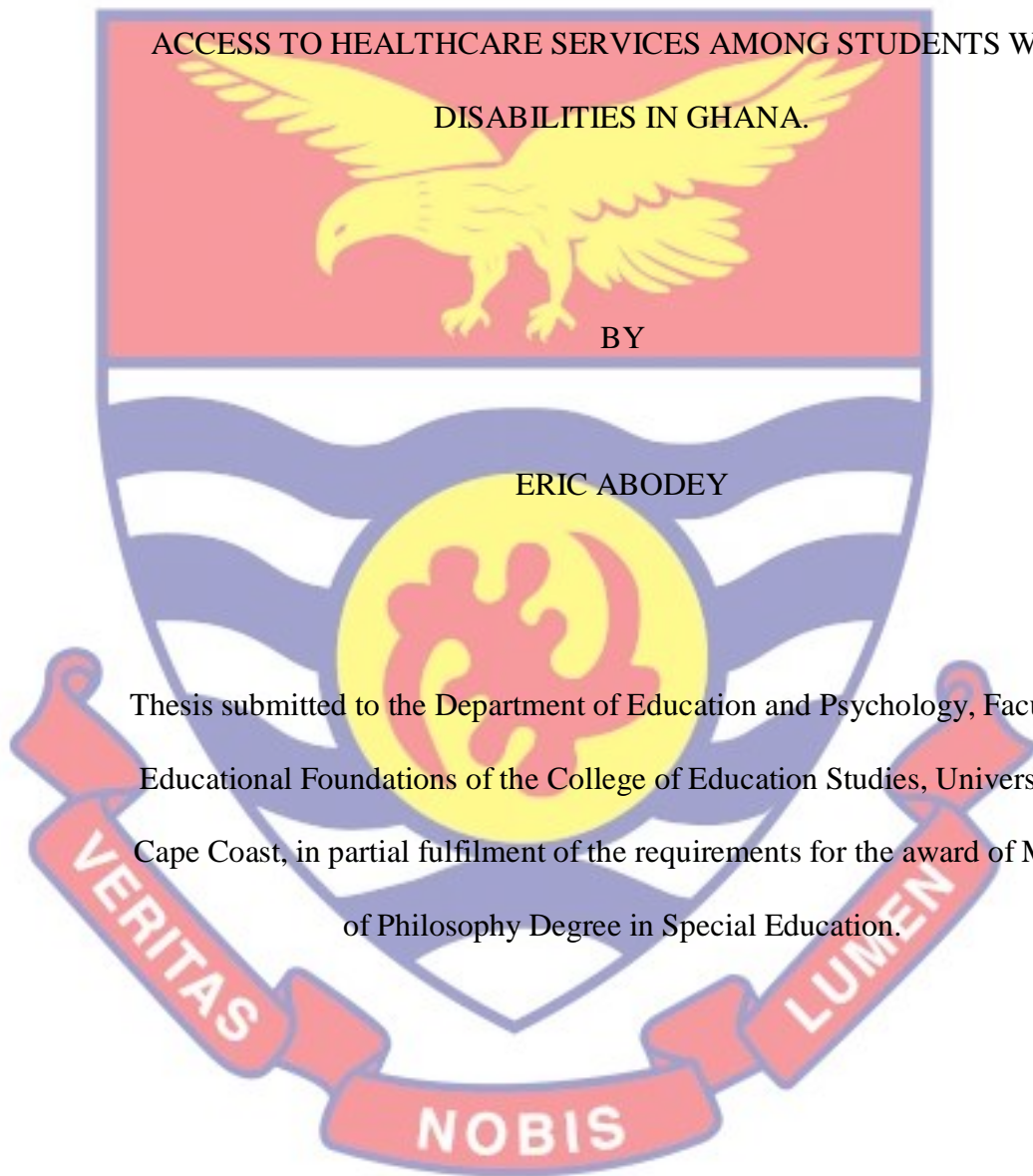
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ACCESS TO HEALTHCARE SERVICES AMONG STUDENTS WITH  
DISABILITIES IN GHANA.

BY

ERIC ABODEY

Thesis submitted to the Department of Education and Psychology, Faculty of  
Educational Foundations of the College of Education Studies, University of  
Cape Coast, in partial fulfilment of the requirements for the award of Master  
of Philosophy Degree in Special Education.



JULY 2018



## DECLARATION

### Candidate's Declaration

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

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

Name: .....

### Supervisors' Declaration

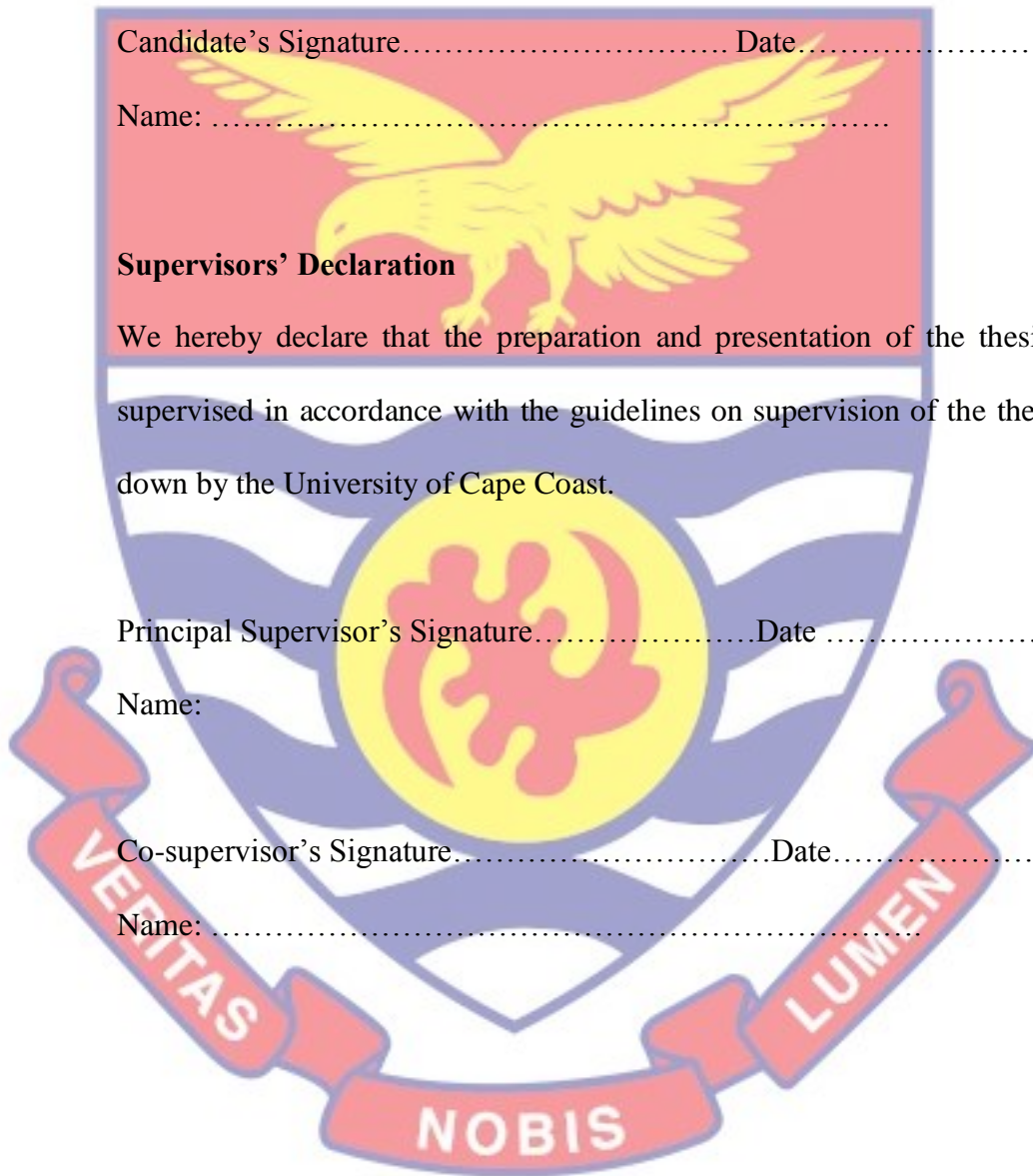
We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of the thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature..... Date.....

Name:

Co-supervisor's Signature..... Date.....

Name: .....





## ABSTRACT

The purpose of the study was to investigate access to healthcare services among students with disabilities (SWDs) in Ghana. Specifically, the study sought to examine accessibility to physical structures of healthcare facilities to students with disabilities, examine the attitude of healthcare providers to SWDs, availability of support services for SWDs in the healthcare facilities and how healthcare service bills are funded by SWDs. I employed qualitative research design dwelling on the phenomenological approach for the study. Purposive sampling technique was used to select a total of 54 participants, which comprises 29 SWDs from the three special schools, 17 healthcare providers (nurses and doctors) and 8 school-mothers for the study. Interview guide was used for data collection. The interview data were transcribed, coded and analysed thematically. The study revealed further that the physical structures of healthcare facilities, inadequate healthcare facilities and financial accessibility were problematic to SWDs in accessing healthcare services in Ghana. The study revealed that the attitudes of healthcare providers towards SWDs were good. Based on the findings, recommendations were made to the Ministries of Health and Housing to revisit existing building regulations and policies to redesign buildings to ensure more disability friendly healthcare structures that will be accessible to SWDs.

## KEY WORDS

Students with Disabilities

Healthcare Providers

Special Schools

Healthcare Facilities

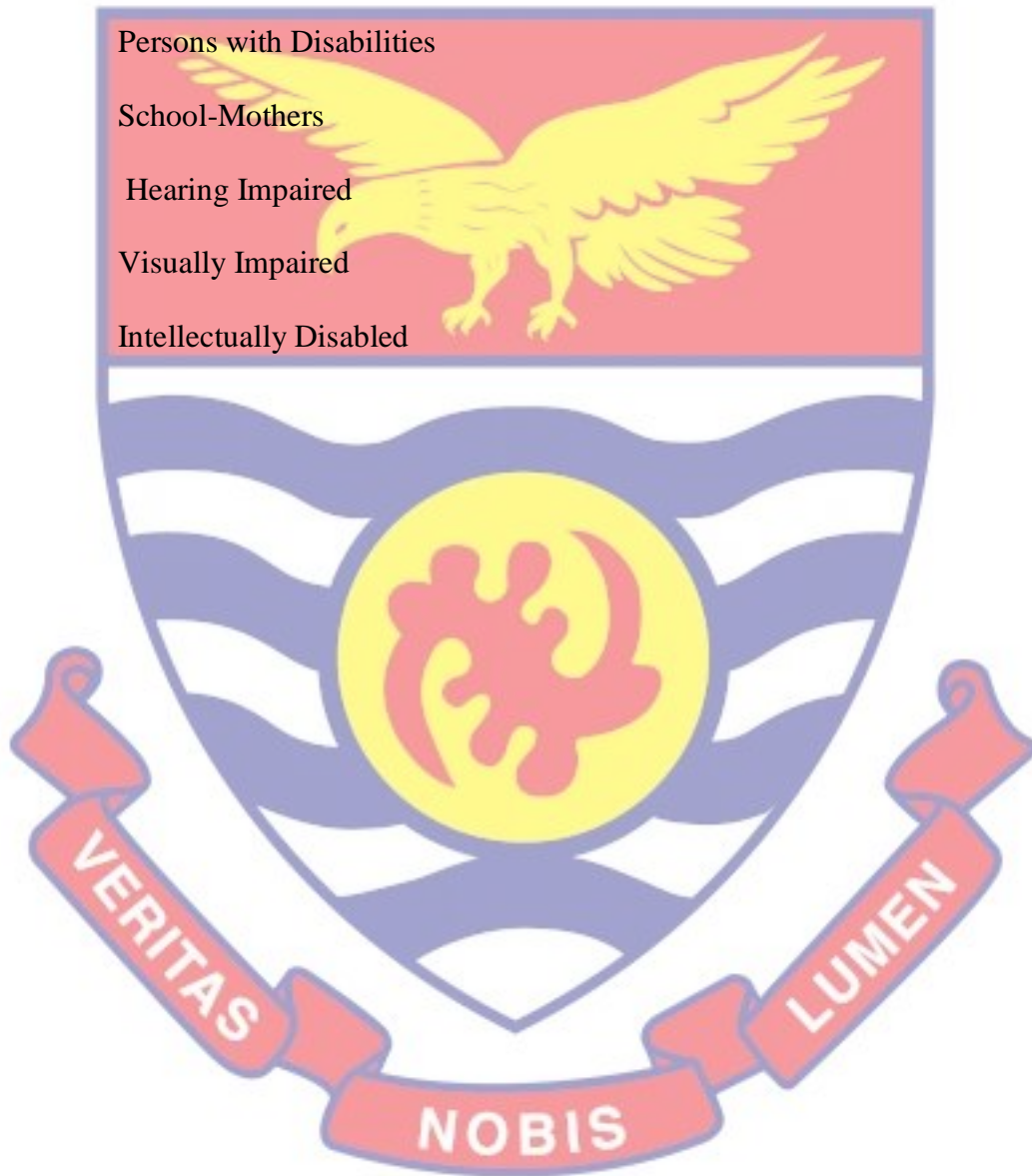
Persons with Disabilities

School-Mothers

Hearing Impaired

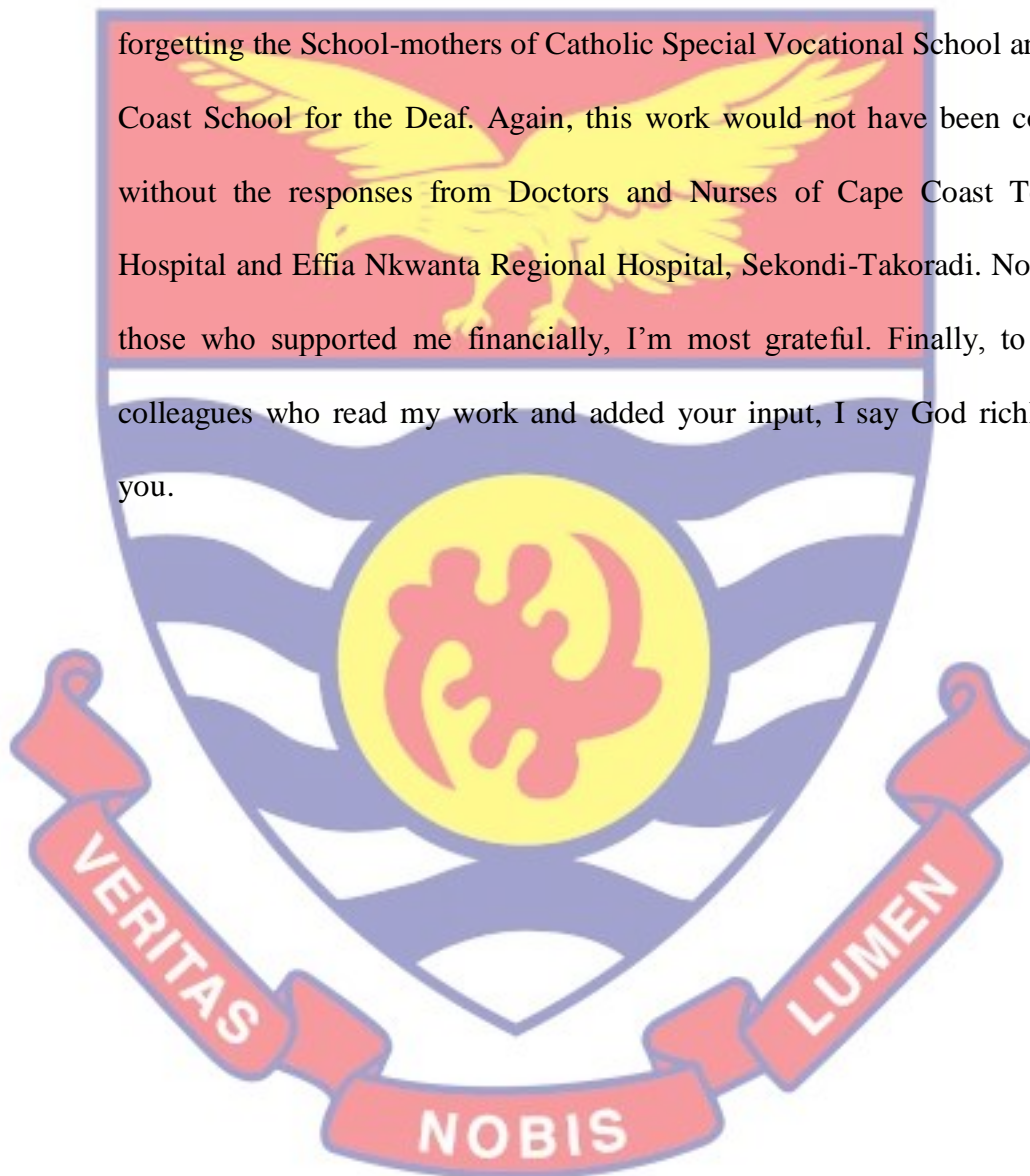
Visually Impaired

Intellectually Disabled



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DEDICATION

To my mother, Doris Azanpana Apobona, and Dr. & Mrs. Yeboah.





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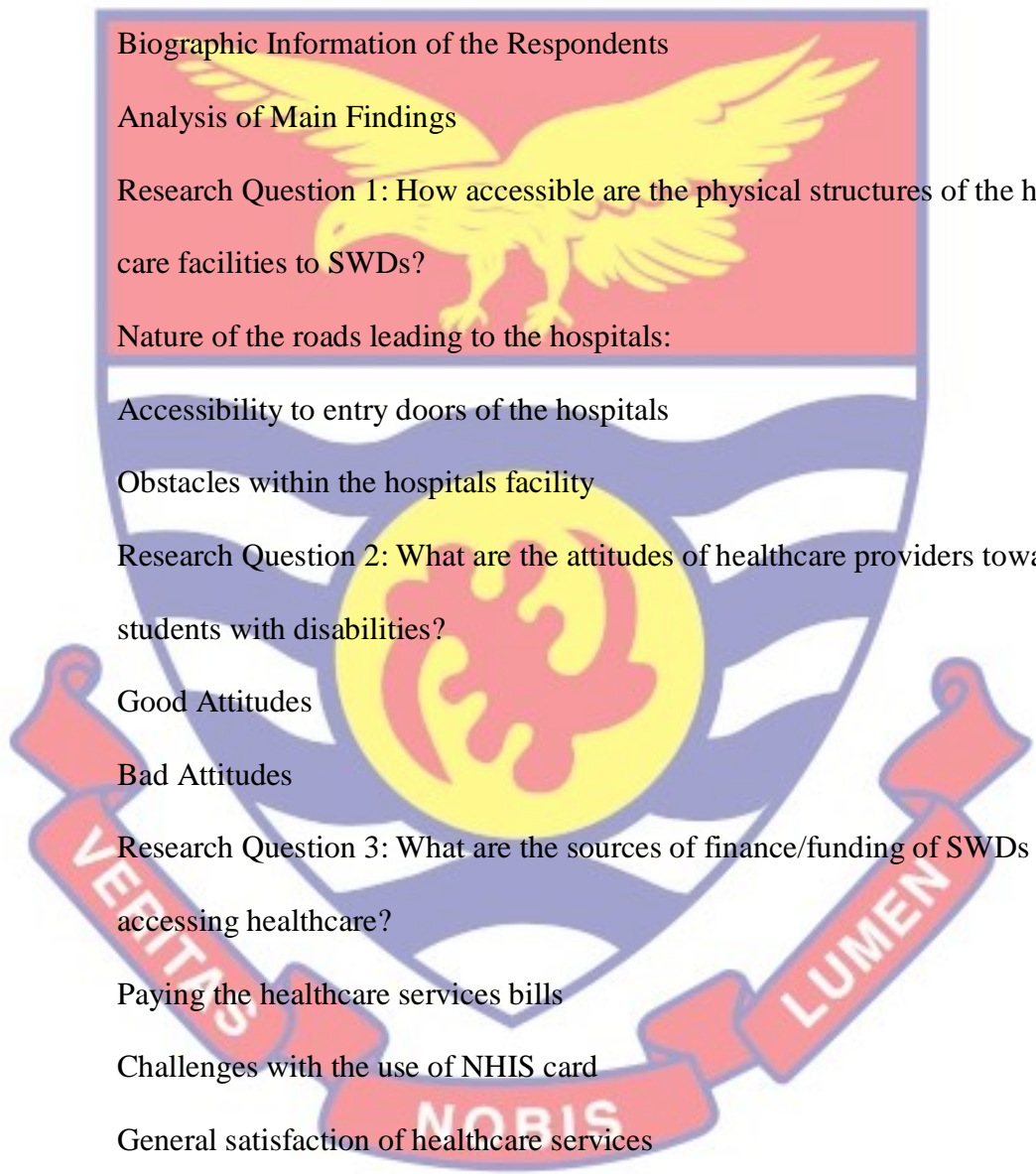
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## CHAPTER ONE

### INTRODUCTION

#### Background to the Study

The health services needs of persons with disabilities is increasingly acknowledged as a research priority (Tomlinson et al., 2009; Mannan & MacLachlan, 2013). The United Nations Convention on the Right of Persons with Disabilities (UNCRPD) (2006) recognised access to health services for people with disabilities at all levels of service provision in a country. Article 29 of Ghana's constitution and the Disability Act (2006) specifically mandates state agencies to ensure that people with disabilities enjoy equal level of access to health services as the general population without discrimination on the basis of their disabilities. The mandates of these state agencies further confirm the 1946 World Health Organisation (WHO) constitution and the Alma Ata declaration of primary health care in 1970, which emphasized the need for equity, social justice, and health for all; community participation; health promotion and appropriate use of resources (WHO, 1946; Lawn et al., 2008). These international regulations specifically promote access to health services for citizens including people with disabilities. The WHO constitution for instance, encourages state agencies to treat access to health services as a human right issue, of which persons with disabilities are not exempted. The efforts demonstrated over the past decades are geared towards achieving universal health coverage for all citizens. In recent developments, the health care needs for persons with disabilities have been spelt out in the Sustainable



Development Goals (SDGs) (UNDP, 2000). Section 3 of the SDGs promotes the need for state agencies to ensure that persons with disabilities are factored in at all stages of health service provision. The 1992 Constitution of Ghana Article 29 clause 6 states that “as far as practicable, every place to which the public has access shall have appropriate facilities for disabled persons” In spite of these efforts, persons with disabilities face numerous access barriers to health care (Badu, 2014).

Globally, access to healthcare among persons with disabilities seems to differ across countries and communities (Rimmer, Riley, Wang, Rauworth & Jurkowski, 2004). Persons with disabilities lag behind other citizens in accessing health care (Rimmer et al., 2014). Persons with disabilities face access barriers to healthcare particularly in low-middle income countries and widen the access gap between themselves and their counterparts in the developed world (Action on Disability and Development, 2005). It is estimated that 5.8% of persons with disabilities around the world do not get care when needed as compared with 3.9% of the non-disabled population (WHO, 2011). Drainoni, Lee-Hood, Bachman, Andrew and Maisels (2006) stated that persons with disabilities may receive healthcare to some extent, however, their satisfaction with the care they receive is low due to delays and frustration. Thew, Smith, Chang, and Starr (2012) and Iezzoni, O’Day, Killeen, and Harker (2004) revealed that hearing impaired patients had fear, mistrust and frustration in healthcare settings when they experience problems with instructions for physical examination, telephone communication, and difficulty in communicating with staff. This may lead to incorrect diagnosis and wrong treatment.

Access to healthcare by persons with disabilities (PWDs) in Ghana is limited despite its emphasis in the disability Act 2006 which calls for effective healthcare and adequate medical rehabilitation service (Mensah, Opong & Schmidt, 2010). Facilities at the various health centres do not provide disability friendly services making it difficult for most clients, especially wheelchair users, to access hospital buildings and climb onto medical examination beds (Mensah et al., 2010). Vulnerable groups including PWDs have differential needs in accessing health care but there is inadequate recognition by stakeholders to specifically identify the differences in need. It implies that policy makers find it difficult to incorporate the needs of disable persons into policy documents and are also unable to integrate these policies in the implementation process (Schneider, Eide, Amin, MacLachlan & Mannan, 2013). Taking together inaccessible physical structure, inadequate skills and knowledge of health workers, limited availability of services, present barriers that hamper persons with disability from accessing healthcare. Notwithstanding, there appears to be very limited research that establishes a direct relationship between these barriers and students with disability in special schools.

Hence the gap in healthcare research among persons with disabilities is to identify empirically barriers that exist in health service delivery in special schools. Although these barriers are widespread in public health delivery, it is not the case with special schools. It is not clear for instance, whether educators, policy makers, parents and other stake holders are aware of the barriers students with disabilities face in accessing health services in special

schools, which in turn affect not only their health but learning, assessment, performance, and class attendance (Hugo, 2013).

The Office of the Surgeon General (2005) noted that the consequence of persons with disabilities failing to receive appropriate, coordinated healthcare as the result of access difficulties alone can result in poor health and increased secondary conditions. Taking a cue from Tomlinson et al. (2009) and Mannan and MacLachlan (2013), there is the need to investigate how special education research can contribute to an increased awareness and understanding of students with disabilities experiences of accessing health services.

#### **Statement of the Problem**

Persons with disabilities across societies have greater risk of experiencing illness and health complications (WHO, 2016). This population is known as the vulnerable groups who are likely to experience severe health outcomes and complications (WHO, 2016). However, across different societies particularly in Africa, they are the group more likely to have unmet health care needs (WHO, 2016). The disability populations are among the groups less likely to utilise preventive and promotive health services (WHO, 2016).

Most PWDs have problems with the physical structures of health facilities whenever they want to access healthcare (Danso, Ayarkwa & Dansoh, 2011). For instance, a study by Kportufe (2015) showed that 80% of government or public buildings, including hospitals do not have ramps nor a lift which makes it very difficult for persons with disabilities to access such buildings. The findings from a study on physical accessibility to public places,



including hospitals revealed that a substantial number of public buildings cannot be accessed by PWDs in Kabul city in Pakistan as there were only few public buildings with elevators (Hasanzada, 2011). The health system and policy makers have failed to explicitly enforce policies that ensure full implementation of laws on accessibility to services for persons with disabilities (Badu, 2014). The few health policies appears to hardly or inappropriately address the needs and concerns of people with disabilities (Badu, 2014). The free exemption payment for health insurance for instance hardly makes full payment for all insurance coverage for persons with disabilities (Badu, Opoku, Appiah, & Agyei-Okyere, 2015).

Furthermore, there is evidence to suggest that health care providers providing services for persons with disabilities have limited knowledge about disability issues and hardly understand disability culture (Badu et al., 2015). This problem mostly relates to the limited in-service and pre-service training for health care providers. Almost all persons with disabilities are recipients of medical attention, support and treatment. As such, they are often subject to the opinions and judgements of service providers in order to gain access to needed services (Khan, Umar, Naeem, & Marryam, 2016). Research shows that the attitudes of healthcare providers towards PWDs are unhealthy and it affects the quality of care (Badu, 2014). Kim, Park, Lee and Kim (2010) in their study compared different attitudes of health professionals towards persons with disabilities and concluded that health professionals had negative perception and attitudes toward individuals with disabilities. Similarly, another study entitled 'Not in my backyard' reported that there is a big negative attitude



which exists among health professionals in dealing with PWDs (Hogberg, 2010).

Additionally, persons with disabilities are more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care (WHO, 2016). Drainoni et al. (2006) found that the absence of specialist such as sign language interpreters in most healthcare centres pose a challenge to hearing impaired patients when accessing healthcare. Thus, often result in communication difficulties between the deaf and the healthcare providers. Studies have again indicated that there exists a lack of appropriate sign language terminology. For example, Patel et al. (2011) reported that British Sign Language does not have a sign for the word cholesterol. In medical practice, language deprivation and associated language dysfluency can contribute to serious misunderstandings (Alexa, Paul & Johannes, 2016). Zazove, et al. (1993) found that DHH persons have significant difficulties communicating with physicians compared to the general public.

Moreover, affordability of health care services and transportation are two main reasons why persons with disabilities do not receive needed health care in low-income countries, 32-33% of non-disabled people are unable to afford health care compared to 51-53% of persons with disabilities (WHO, 2016).

Clearly, the revelations outlined by the aforementioned studies indicate that physical structure, attitude of healthcare providers, availability of sign

language interpreters among many other things pose challenges to PWDs when accessing quality healthcare in most healthcare facilities.

In Ghana, the challenges that SWDs face regarding healthcare access are not well documented. This is because most studies done in Ghana regarding PWDs focused on barriers to social participation for the deaf and hard hearing (Nortey, 2009), and financial barriers that PWDs face in accessing healthcare (Badu, 2014).

This creates a knowledge gap specific to challenges that students with disabilities (SWDs) face in Ghana when accessing quality healthcare. Therefore, this study investigates the barriers students with disabilities face in accessing healthcare services.

#### **Purpose of the Study**

The main purpose of the study is to assess barriers that SWDs face in accessing health care services in selected special schools in Ghana. The specific objectives of the study are to:

1. examine SWDs accessibility to the physical structure at health facilities.
2. examine the attitudes of healthcare providers towards students with disabilities (SWDs)
3. determine sources of finance of SWDs in relation to their access to healthcare services
4. investigate the available support services given to SWDs at the healthcare centres to facilitate access to healthcare services

## Research Questions

The study is guided by the following research questions;

1. How accessible are the physical structures of health care facilities to SWDs?
2. What are the attitudes of healthcare providers towards SWDs?
3. How do SWDs finance/fund their healthcare services bills?
4. What support services are given to SWDs at the healthcare centres to facilitate their access to healthcare services?

## Significance of the Study

The findings of this study would reveal the barriers SWDs have when accessing healthcare services. This will inform school authorities and the Ministry of Education about the challenges that are encountered by SWDs. It will unravel the access barriers that SWDs face as far as the physical structures of health care facilities are concerned. Also, it would create awareness for health care providers about the healthcare needs of SWDs. The findings of this study will again, serve as empirical evidence or will serve as basis for parents whose children are in the special schools on how their children access healthcare. Parents will get to know the challenges or barriers these children face in accessing healthcare. Research has shown that parents whose children are in some special schools neglect the children to their own fate without visiting them on regular basis because of societal stigmatisation attached to having children with disabilities (Mushtaq, 2015; Besten, Cornielje, Cornielje & Botwey, 2016). Furthermore, the study would help us to know the available healthcare services offered in these facilities. In addition, findings from the study would bring to light the availability of health



care facilitators such as sign language interpreters for SWDs in the health care facilities and the selected special schools. Additionally, the findings from the study would make it possible to have information about the common healthcare needs of SWDs in the selected special schools. Finally, the study would serve as reference point for other researchers who would want to research on the same topic in different regions or municipalities.

### **Delimitations**

The study was delimited to access barriers that students with disability face in accessing healthcare services in special schools in Ghana. Geographically, the study was conducted in only three regions in the country, namely; Western, Central and Eastern. In addition, the study focused on only students with visual impairment, hearing impairment and intellectual disability. Furthermore, nurses and medical doctors were not left out so were the house-mothers of the selected schools. Students who were eighteen years and above were selected from the schools for the interview. Finally, the study did not involve the teachers who are teaching the students. This is because I felt that the teachers would not be able to give me the needed information as compared to the students.

In content, the study was delimited to access to healthcare services. Specifically, the challenges that SWDs are confronted with when accessing healthcare services. This included the attitudes that healthcare providers show towards SWDs when accessing healthcare services, the accessibility of the physical structures of the various healthcare buildings, how the cost of these SWDs healthcare services is funded and finally, the special services offered by the various healthcare centres.



## Limitations

In the first place, generalisation of result of the findings could not be made to cover the entire special schools in Ghana because of the qualitative method of enquiry that was employed. In the Catholic Special Vocational School, I intended to use a minimum of 10 mild-intellectually disabled students but I could not get the required number. In view of this I had to interview the house-mothers to augment the number that was stated for the study. Cape Coast School for the deaf also had it challenges. I had to ask the respondents questions and then a teacher translated it into sign language for another teacher to interpret the sign orally for it to be recorded. This could affect the data because once information travels from one medium to another; there is the possibility that the information may be distorted. Again, due to the possibility that some of the sign language interpreters may not be able to interpret exactly what was written on the paper as far as the interview questions were concerned, the students may not be able to provide the exact information needed. This may affect the validity and reliability of the data. There are also chances of biases in the presentation of the results of the researcher. However, I was very cautious and objective enough to ensure that the results presented are in their unadulterated state.

## Definition of Terms

**Students with disabilities** are students with impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these.

**Healthcare providers** are individuals who provide preventive, curative, promotional or rehabilitative healthcare services in a systematic way to people, families or communities.

**Special school** is a school catering for students who have special educational needs due to severe learning difficulties, physical disabilities, sensory impaired or behavioural problems.

**Healthcare facilities** are places where healthcare services are provided.

**Persons with disabilities** are persons with impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or a combination of these.

**House-mothers** are mothers who are with the SWDs in the special schools.

### **Organisation of the Study**

The study is organised in five chapters. Chapter one outlined the introduction of the study which centred on the background to the study, statement of the problem, purpose of the study, research questions, significance of the study, delimitation of the study, limitations of the study and operational definition of terms. Chapter two presented the review of related literature, it emphasized specified concepts, presented the theoretical frameworks as well as related empirical studies. Chapter three focused on the research methods that were used in the study. This comprises the research design, population, sample and sampling procedure, research instrument, data collection procedure and data analysis procedure. Chapter four presented analyses and discussion of the results of the study.

Finally, chapter five provided a summary of the research process, key findings, conclusion, recommendations based on the findings of the study and areas for further research.



## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

This Chapter presents the review of related literature. It includes the conceptual review/framework, theoretical review and empirical review.

#### Conceptual Review

#### Concepts of Accessibility

Badu (2014) noted that accessibility is one of the important components in determining barriers to healthcare for PWDs. It is also one of the most important components in determining barriers to healthcare for SWDs. Sowney and Barr (2004) defined accessibility as the services being easily available not only in terms of distance, but also in terms of time and ethos. They further said that, accessibility concerning time could be seen in three dimensions. Firstly, the time a client will consume to reach the healthcare centre, secondly, the time needed to wait to be attended to after the patient or client has reached the healthcare centre and finally the time needed to wait if a referral is required. It is important to note that access includes making use of available resources and not only limited to finding your way to the service centre.

In addition, accessibility has been identified in both national and international legislations and regulations as standards. In Article 29(6) of 1992 constitution of the Republic of Ghana, it is stated, “as far as practicable, every place to which the public has access shall have appropriate facilities for



disabled individuals”. Hotels, school buildings and health services buildings such as hospitals, clinics, rehabilitation centres, public health offices, and social welfare offices are no exception. Again, according to Rule 5 of the standard rules on the equalisation of opportunities for PWDs and the UN Convention on the rights of Persons with Disabilities (CRPD) (2006), the demand for accessibility is a way of creating equal opportunities for PWDs in all manner of life (United Nations Department of Public Information, 1994). In this respect, SWDs are no exception.

In view of the above conventions, accessibility can be categorised into physical or environmental, information and communication, financial and economic accessibility. However, Hwang et al. (2009) state that accessibility regarding healthcare can be grouped into two categories namely structural and process accessibility. Structural barriers according to their study comprise the physical access to health service buildings whereas the process barriers involve the difficulty that a patient goes through in arranging appointments with a service giver. It also involves difficulty in obtaining health insurance coverage. Such barriers are critical and worth attended to and thus if addressed properly will minimise access barriers to healthcare for SWDs.

### **Concept of Physical Accessibility**

Physical accessibility is the condition of the physical environment that determines the utilisation of services (Kroll, Jones, Kehn, & Neri, 2006). It is how accessible physical structures such as hospital buildings, door entrances, washrooms facilities and scale are to PWDs. It can be deduced that physical accessibility to students is defined as how accessible physical structures such as hospital buildings, door entrances, washrooms facilities and scale are to

SWDs. It also includes how accessible roads leading to healthcare point are to SWDs which include pavement and parking spaces adapted to be used by visually impaired and wheelchair users respectively. Again, it includes medical equipment as well as presence of adjusted tables, mammography machines and assistive devices designed for SWDs usage (Hwang et al., 2009; Iezzoni, Killeen & O'Day, 2006; Donnellan, 2001). Studies in Pakistan have found that, factors such as transportation to healthcare centres, distance and time to reach healthcare setting certainly influence healthcare utilisation (Stephenson & Hennink, 2004; Shaikh & Hatcher, 2005). This is particularly serious among SWDs who require special assistance.

According to a 2007 study on disability and inclusive development in United Kingdom, a physical accessible environment is an important component in creating welcoming and inclusive environments in which all children can learn (Burke, 2013). Although the study clearly focused on education, it is however necessary to understand that not only in education but also in the area of healthcare, accessible physical environment can be used by countries to build inclusive environment and society where all persons can secure healthcare to be able to achieve the universal healthcare target of the WHO. In view of this, physically accessible environment and structures have been the priority of the United Nations and its member countries for PWDs (Burke, 2013). Following the Convention on the Right of Persons with Disabilities (CRPD) (2006), it has become relevant that disability issues be incorporated into building regulations. This will ensure that new buildings will be designed to meet the requirements of the building codes. In the construction of these structures, architects and engineers should therefore factor disability

related issues into the plan. Old buildings however, can also be modified to make it accessible to all SWDs. Medical equipment and facilities are all essential in this revision. Therefore, proper monitoring and implementation are needed to ensure that all hospital structures, roads and medical equipment are in conditions that can be accessed by all manner of persons without discrimination (CRPD, 2006).

The CRPD has highly been welcomed in almost all member states of the United Nations. However, there is a comparable difference in performance among countries towards this global goal. Some countries have moved a step ahead in implementing the convention to ensure proper monitoring and implementation of physical accessibility issues. According to the Human Rights Education Associates (HREA, 2007), in countries like Australia, United States, India and United Kingdom, national anti-discrimination law have been passed and implemented in fulfilling participation of PWDs in all sectors of the economy. This law in these countries came into operation even before the coming of the CRPD. Some other countries still remain in the pipeline towards this agenda. Out of 158 countries who are signatories to the convention, 138 countries have ratified it. Even in some countries that claim to ratify the convention, there has still not been a legislative instrument to make it legal (United Nations Human Rights, 2011). For instance, according to the Disabled World publication on health and disability news and statistics for Africa, although South Africa has signed and ratified the CRPD in 2007, it has still not reached its task to implementing the convention (Disabled World, 2009).



In Ghana, the Accra International Conference Centre (AICC) and National Theatre (NT) which host most national and international events are not universally designed to make it accessible to PWDs such that car parks, main entrances, staircases, corridors, ramps are not accessible for disabled persons (Badu, 2014). Other things like braille texts, seat for wheelchair users, underfoot warnings were absent (Danso, Ayarkwa & Dansoh, 2011). These make the physical environment very difficult for SWDs to access. According to Owusu and Owusu-Ansah (2011) construction companies and estate managers and developers do not incorporate disability issues into their construction designs although the Disability Act and the Constitution mandate these. Owusu and Owusu-Ansah concluded that all stakeholders have the responsibility to embark on serious public awareness campaigns on the importance of universally designed buildings in the country to accommodate the needs and the interests of SWDs.

### **Information and Communication Accessibility**

Information and communication accessibility may refer to how accessible information is to PWDs (Badu, 2014). Information and communication are very essential in human development since language is the building block of all human activities and interactions. Nolan, Moonie and Lavers (2005), therefore, said that, communication is all about the way people reach out to one another. It is an essential part of all relationships, and the ability to communicate well with service users, colleagues and others is a basic requirement for doing your job.

SWDs may experience frustration and isolation when the language spoken by service providers is not accessible to them. A hearing impaired



person will find it difficult to respond to a verbal communication therefore the possibility of the person to feel abandoned in a healthcare facility where proper mechanism to address these challenges is not done is high. Such a person may feel being excluded from service point setting as a result of communication barrier. For example, Thew, Smith, Chang and Starr (2012), revealed that deaf patients experience fear, mistrust and frustration at healthcare facilities. These occur when the patient experiences problems with instructions for physical examination, telephone communication and difficulty communicating with staff (Iezzoni, O'Day, Killeen & Harker, 2004). This may also lead to disappointing service delivered to such a person, incorrect diagnosis, and improper treatment leading to violation of the right to healthcare (Haricharan, Heap, Coomans & London, 2013). As it is believed that every profession has its own special words and terminologies, some service users such as deaf and blind may feel excluded as they encounter some of these terminologies. There are also other people who may find it difficult to hear certain sounds at some pitch level (tone) or when there is noise at the background.

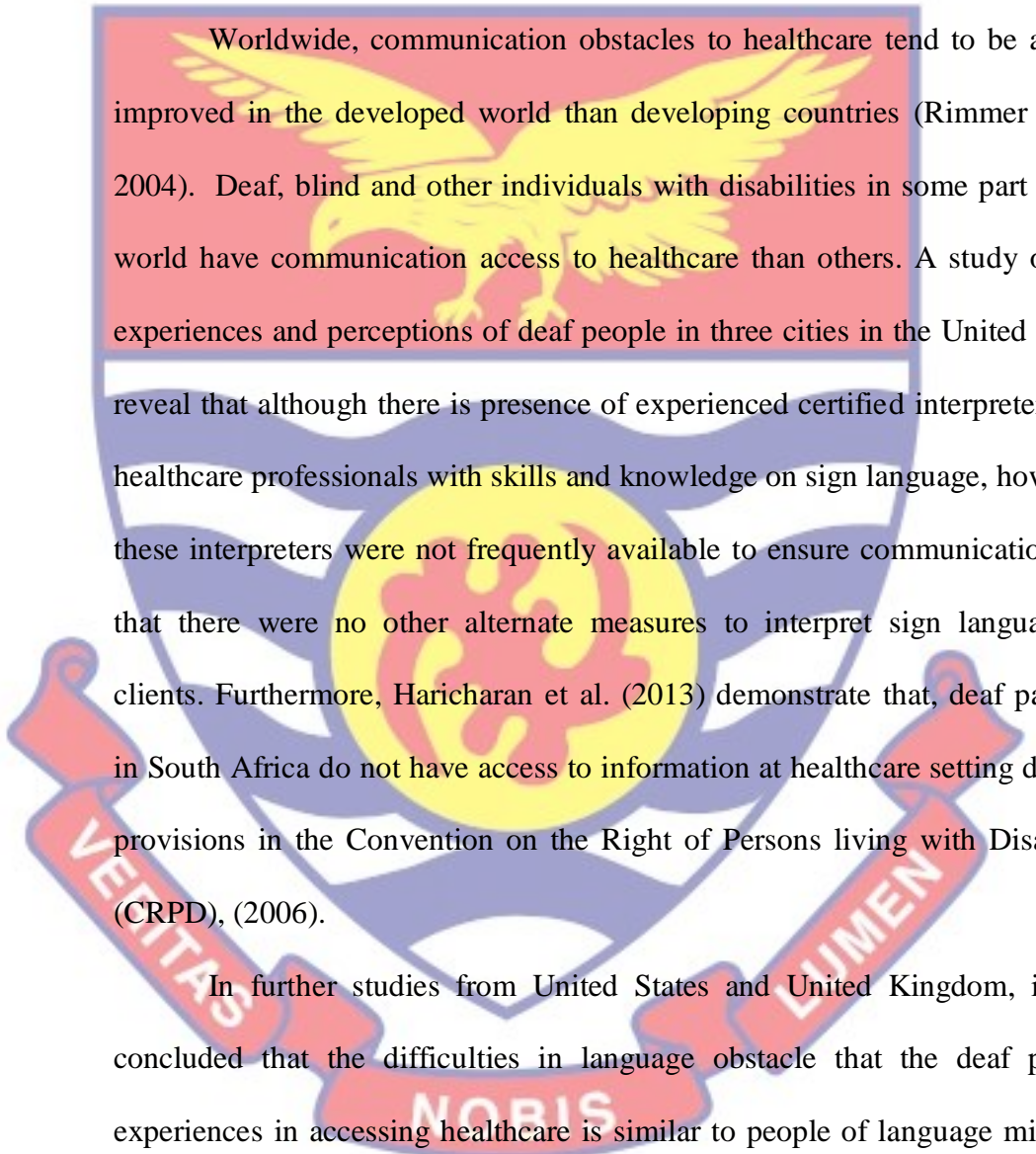
However, experiences of visually impaired persons in communication difficulty are different from the hard of hearing person. A visually impaired person may not be able to pick signals given out as well as not be able to give out appropriate signals in communication. This is because they are ignorant of these signals. As a result of this, understanding such a person's attitudes, feelings and behaviour will be mismatched. Such communication (non-verbal) can easily be interpreted differently by professionals and it can be misleading (Nolan, Moonie & Lavers, 2005). This therefore, means that healthcare

professionals should be able to learn to communicate comprehensively with SWDs.

According to Donnellan (2001), to help PWDs, information should be available in plain language like English, large print, spoken on audiocassette or via a speech synthesizer and braille. Specifically, people with hearing impairment need sign language interpreters or subtitles available to them when necessary to make information accessible. This confirms what Steinberg Barnett, Meador, Wiggins and Zazove (2006) found in the United States that, communication is well coordinated in an environment where medically experienced certified interpreters are available for deaf patients. In another development, a study of communication for adult nurses by McEwen and Kraszewski (2010) demonstrated that, a rebalancing of relationship between service providers and patients will ensure that patient expectations of healthcare are met. The study further elaborates that it can only be achieved when patients can make preferences without barriers and professionals recognise such patient's communication difficulties. These barriers may not be different in the Ghanaian context. In view of these, questions that every healthcare professional needs to ask as far as providing service to SWDs may include;

1. Are the prescriptions and other information given at hospitals available in braille text to make it accessible to the visually impaired student?
2. Are there sign language interpreters at service points to make information accessible to the hearing impaired student?
3. Are there communication boards to make information available to a student with speech disorder?

These are the most pressing questions that we need to ask to find out how accessible communication is to SWDs as they seek healthcare. All the information written on drugs (drug prescription) and provided at service points may become relevant to only those who may be able to read, interpret and understand the information.

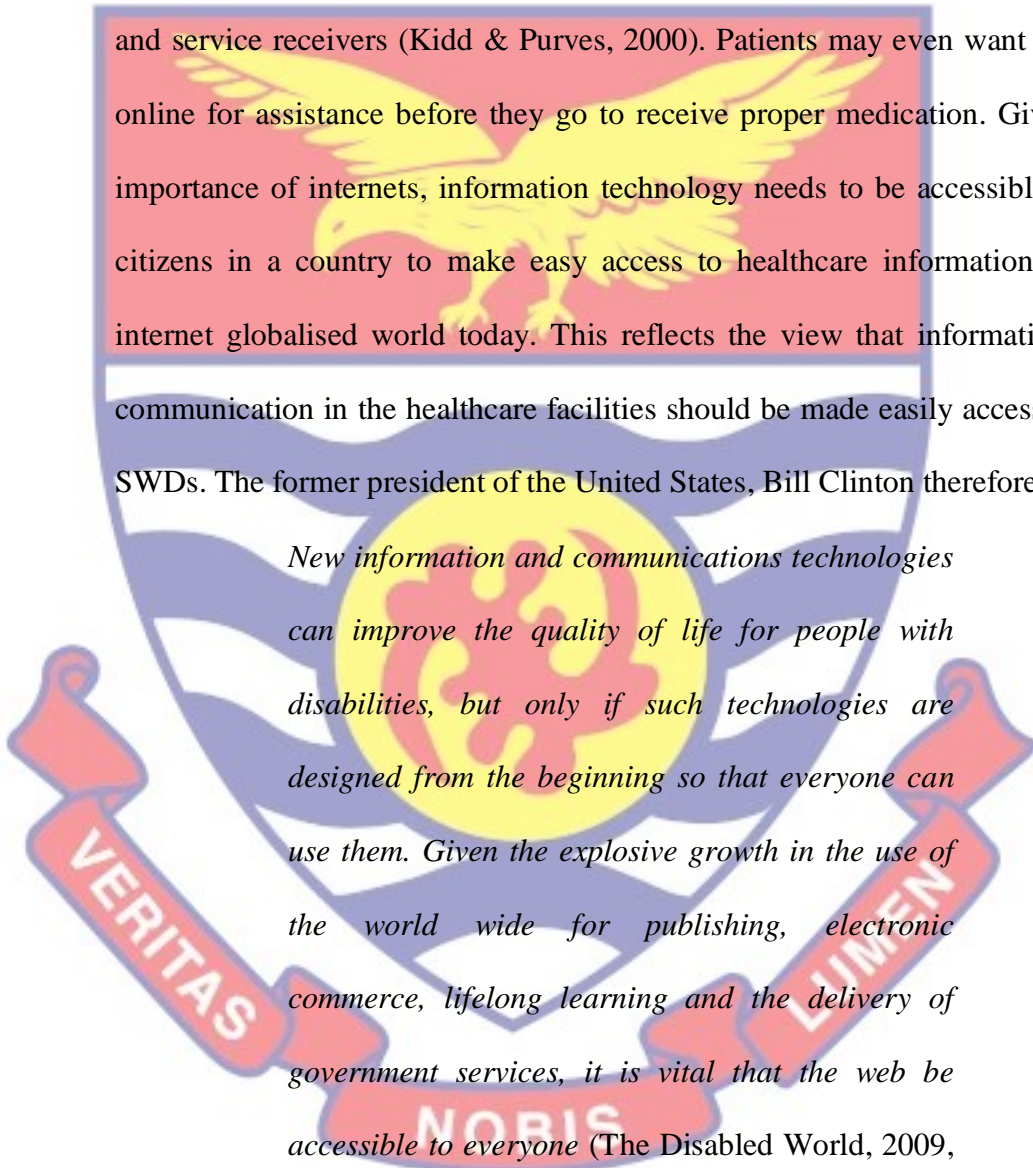


Worldwide, communication obstacles to healthcare tend to be a little improved in the developed world than developing countries (Rimmer et al., 2004). Deaf, blind and other individuals with disabilities in some part of the world have communication access to healthcare than others. A study on the experiences and perceptions of deaf people in three cities in the United States reveal that although there is presence of experienced certified interpreters and healthcare professionals with skills and knowledge on sign language, however, these interpreters were not frequently available to ensure communication and that there were no other alternate measures to interpret sign language to clients. Furthermore, Haricharan et al. (2013) demonstrate that, deaf patients in South Africa do not have access to information at healthcare setting despite provisions in the Convention on the Right of Persons living with Disability (CRPD), (2006).

In further studies from United States and United Kingdom, it was concluded that the difficulties in language obstacle that the deaf person experiences in accessing healthcare is similar to people of language minority or patients with limited English-Language proficiency (Patel et al., 2011) The services of professional interpreters can also facilitate healthcare of these groups of language minorities (Barnett & Franks, 2002; Jacobs et al., 2001).



Additionally, new information and communication technologies may create barriers to healthcare for SWDs. With the wide spread of internet in the increasingly globalised world of today, information on some specialised healthcare facilities are mostly available on the internet. This shows improvement in access to information regarding healthcare for practitioners and service receivers (Kidd & Purves, 2000). Patients may even want to visit online for assistance before they go to receive proper medication. Given the importance of internets, information technology needs to be accessible to all citizens in a country to make easy access to healthcare information in the internet globalised world today. This reflects the view that information and communication in the healthcare facilities should be made easily accessible to SWDs. The former president of the United States, Bill Clinton therefore said:



*New information and communications technologies can improve the quality of life for people with disabilities, but only if such technologies are designed from the beginning so that everyone can use them. Given the explosive growth in the use of the world wide for publishing, electronic commerce, lifelong learning and the delivery of government services, it is vital that the web be accessible to everyone* (The Disabled World, 2009, p.92).

Given the significance of the internet, however there is a considerable gap in access to internet usage between developed and developing countries. According to the World Bank (2012) data on internet users per 100 people



shows that, while in the United States 81.1% of the population have access to internet usage only 17.1% of Ghanaian population have access to internet usage. Comparing this rate to Tanzania, only 13.1% of Tanzania have access to internet usage. It is however difficult for one to pinpoint the rate of access to internet usage among SWDs in Ghana since no accurate statistics or data is found to represent them (World Bank Indicators, 2012).

### **Financial Accessibility**

Affordability and measures to finance healthcare is one of the important factors in determining access among SWDs. Costs of healthcare may occur in two different dimensions that is the one directly related to treatment and the other indirectly related to transportation, expenses on people or caregivers accompanying patients to hospital and expenses on lodging and feeding (Peters et al., 2008).

Financial accessibility is the economic status of the person that determines whether he can afford the cost of health service or not. Healthcare is basically accessible to people in the society who can afford to pay for the cost (Badu et al., 2015). However, the poor in society become more vulnerable as a result of economic polarisation and lack of social security. Poor communities are not able to mobilise revenue towards health insurance scheme attributed to the fact that they are mostly unemployed (Badu et al., 2015). This affects their membership in insurance schemes which is a major contributing factor to their exclusion in lower income communities particularly rural areas (Preker & Carrin, 2004). Thus, they are limited in contributing to decisions that affect their healthcare and as such may be excluded from the healthcare system (Peters et al., 2008; Xu, et al. 2006).

Generally, researchers have established that disability has a direct relationship with poverty and access to healthcare in poor settings like the rural setting (Elwan, 2009; Lwanga-Ntale, 2003). Therefore, gaining access to healthcare becomes difficult for the poor especially SWDs. The WHO fact sheet on disability shows that, a substantial gap exists between affordability of health services among disable and non-disable population. The rate of non-disable persons who are unable to pay for healthcare as compared to disable is 32% to 33% and 51% to 52%, respectively (WHO, 2013). According to a study by Muderedzi and Ingstad (2011), PWDs are at high risk of developing health related problems. This means they are unlikely to live a healthy life and consequences that follow. These may include malnutrition, hunger and developing different types of diseases. Disability can also cause poverty resulting in poor health such that the individual will be limited from fully participating in economic activities. Therefore, learners with disability particularly those in the rural settings comparatively experience much more difficulty in accessing healthcare than those in the urban settings as a result of cost of healthcare. The marginalised groups who are described as poor and hence PWDs find their ways to the traditional village healers (Last, 2008; Brocklehurst & Costello, 2003).

Furthermore, not all disability types have the same health needs. Some disabilities require that they have regular medical check-ups, rehabilitative services (therapy services) and assistive services (DeJong, Palsbo & Beatty, 2002). Financial accessibility to healthcare may therefore limit SWDs from meeting the regular care they need. Additional expenses on cost of transportation and time may create barriers to healthcare for SWDs who are

distanced from the services point. For example, Apoya and Marriott, (2011) assert that, one quarter of the Ghanaian population is over 60 km away from a health care facility. In circumstance where resources of PWDs may not meet transport costs, they may experience barrier to healthcare. Grut, Mji, Braathen and Ingstad (2012) identified that, it is essential to consider certain factors when delivering healthcare to PWDs who are located at poor resource settings. Given that, such person's history, resources, needs and capabilities of his or her family members are significantly noted. The study again established that there is a relationship between poverty, rural setting, disability and access to health service in Amathole District in South Africa.

### **Prevalence of Disability**

Worldwide, data about disability issues are difficult to identify since much surveys have not been conducted in the field regarding the prevalence rate. This problem is evident in Africa and most developing countries and for that matter Ghana. Myths and beliefs are one of the reasons associated with disabilities. It affects families with disable persons to the extent that they hide their disabled relatives to prevent them from participating in most surveys being conducted. This therefore has a negative effect on the result from surveys. It generates different prevalence rates of disability on surveys conducted by individual institutions and make it not reliable. For instance, it is captured in the 2002 Country Profile on Disability in Federal Democratic Republic of Ethiopia that, disabled persons are associated with spiritual evil by some people and are being prevented from going to the public (Badu, 2014). This leads to inaccurate statistics and information on disability in the country (Japan International Cooperation Planning and Evaluation, 2002).



To put it another way, Mont (2007) was also of the view that, due to variation in the definition of disability as a result of differences in nature and severity across places and time, it is difficult to get prevalence rate that is internationally comparable and understandable. The measurement of disability therefore differs and depends greatly on the reason for the measurement. He further argues that a single prevalence rate of disability can be seriously problematic and that emphasis should be placed on interval prevalence rate, that is, two prevalence rates with one being moderate threshold and the other more severe threshold on functional limitation.

Despite Monts' explanation, there are prevalent rates from UN agencies that are highly welcome. Globally, more than one billion people live with some form of disabilities (WHO, 2016). This represents 15% of the world population. The prevalence rate is higher in low income countries than developed countries. It is also higher in females than males. People who have significant difficulties in functioning fall between 2% to 4% representing 110 to 190 million respectively (Badu, 2014). Factors such as aging, increases in chronic diseases, natural disasters, road traffic accidents, conflicts and others continuously increase the prevalence rate of disability around the globe. In every developing country, the prevalence rate of disability is estimated at 10% to 15% of that country's population (WHO, 2013; Disability and Health, 2013).

However, In Yemen, the rate has been estimated differently by different surveys ranging from 0.4% to 12% of the total population (Grut & Ingstad, 2006). The 2004 Yemen population census estimated the prevalence rate at 1.9% representing 380,000 of the country's population. Other estimates



from Disability Fund indicate that, every year there is about 15,000 new incidents of permanent impairment as a result of traffic accidents in Yemen (Grut & Ingstad, 2006). Comparatively, International Labour Organization found that, over 9% of Tanzania's population live with some form of disability (McNally & Mannan, 2013). Another study on family perceptions of intellectual disability conducted in Dares Salaam revealed that, the rate of disability in Tanzania in 2008 stood at an estimate of 2.4 million representing 8% of the population (Aldersey, 2012). This explains why the prevalence rate of disability in most developing countries is not reliable since it differs from organisation to organisation.

Using WHO estimates of disabled people in developing countries to be 10% to 15%, the disable population in Ghana is between 2.4 million to 3.6 million. This is based on the 2010 population and housing census which gives the population of the country as 24.6 million. However, the 2010 population census found the prevalence rate of disability in the country at 3% of the entire population which represents 737,743. According to this population and housing census, females with disabilities are more than males. The number of males with disabilities is 350,096 peoples and females with disabilities 387,647 peoples. There are also regional disparities in the prevalence rate of disability in Ghana. The Ashanti region has the highest prevalence rate of disability while Upper West has the lowest number of people living with some form of disabilities. The disabled population in Ashanti region is given as 124,501 people which represented 2.6% of the total Ashanti region population of 4,780,380 people (The Ghana Statistical Service [GSS], 2012).

This rate of disability given by GSS both at the national and regional levels is relatively arguable as it falls below the estimated rate of 10% to 15% in developing countries captured by the WHO. This has raised concern by most stakeholders in the field of disability in Ghana on this prevalence rate since it is not reliable and cannot be used to formulate and design programmes for PWDs in the country (Badu, 2014). Comparing the prevalence rate to other parts of Africa, it can be deduced that almost all the rates captured under the national census in most African countries is comparatively lower than those conducted by United Nations (UN) agencies such as the International Labour Organisation and the WHO (Badu, 2014). Also, the census however did not estimate the prevalence rate of disability by metropolis.

### **Theoretical Framework**

#### **Health Service Utilisation Model**

This study is guided by the Health Service Utilisation Model. The healthcare utilisation model was propounded by Ronald M. Andersen in 1968 in the United States of America. He was a health service researcher and medical sociologist. He developed the model from a survey for the Center for Health Administration Studies and the National Opinion Research on families' use of health services (Aday, Andersen, & Fleming, 1980; Andersen, 1992; Andersen, 2008). Since the initial development of the theory, it has undergone several modifications. It was reviewed in 1973 by Andersen and Newman (1973), Andersen (1995), Gelberg, Andersen, and Leake (2000), and Andersen and Davidson (2001). The model has been applied in various fields such as sociology, medicine, public health and psychology.

The model is a multilevel theory which incorporates both contextual and individual level predictors of health services utilisation. In doing so, it divides the major components of contextual characteristics in the same way as individual characteristics have traditionally been divided thus, those that predispose, enable or suggest need for individual use of health services (Andersen, 2008). There are three main tenets of the theory. They are predisposing, need, and enabling factors. It describes how these factors come to play to influence the utilisation of health services (Andersen, 2008). The main tenants of the model are elaborated as follows:

**Predisposing factors:** According to the Health Utilization Model, predisposing factors are the demographic characteristics of individuals which include; sex and age as “biological imperatives” (Andersen & Davidson, 2001, p.7); social factors such as religion, occupation, education, ethnicity, attitude towards health, and social relations (such as family status); mental factors in terms of health beliefs. For example, values, attitudes, and knowledge on health and health- related services (Andersen, 1992; Andersen, 2008); and contextual factors including the social and demographic composition of communities, organizational and collective values, political perspectives and cultural norms, which predispose individuals to the use of health services.

**Enabling factors:** According to the model, enabling factors are described as being external to the individual but important in influencing his/her decisions concerning the use of health services. Organisational and financing factors are considered to serve as conditions enabling health service utilisation (Andersen & Davidson, 2001; Babitsch, Gohl, & von Lengerke, 2012). These organisational and financing factors occur at both individual and contextual



levels. Individual financing factors comprise the wealth and income at the disposal of an individual which enables him/her to pay for the utilisation of health services and the effective price of health care which is determined by cost-sharing requirements and the individual's health insurance status (Andersen, 2008). Individual organisational factors have to do with access to a regular source of care and the nature of that source. They also include, travel time to the health facility, the means of transportation, and waiting time for healthcare (Andersen & Davidson, 2001; Babitsch, et al., 2012).

The model posits that at the contextual level, financing encompasses the resources available within the setting for health services such as affluence, per capital community income, the level of health insurance coverage, methods of compensating providers, the relative price of goods and services, and health care expenditures (Babitsch et al., 2012). Organisation at the contextual level denotes the amount, locations, varieties, structures, and distribution of health personnel and facilities. It also involves office hours, hospital and physician density, quality management oversight, provider mix, and education and outreach programmes. Health policies also constitute organisational contextual enabling factors (Andersen & Davidson, 2001; Babitsch et al., 2012).

**The need factors:** The need factors according to the model refer to perceptions of the seriousness of a disease or health condition (Andersen & Newman, 1973; Babitsch et al., 2012), and just as the enabling factors, exist at both the individual and contextual levels. At the individual level, the model distinguishes between perceived need for health services (how people perceive and experience their own health status (self-rated health), functional state and



illness symptoms) and evaluated need (objective measurements of patients' health status and professional assessments, and need for medical care) (Andersen & Davidson, 2001; Babitsch et al., 2012).

At the contextual level, individuals make a differentiation between population health indices and environmental need characteristics (Babitsch et al., 2012). Environmental need according to the model, points to the health-related circumstances of the environment (e.g. occupational and traffic and crime-related injury and death rates). Population health indices on the other hand are the overall measurements of community health, including epidemiological indicators of disability morbidity, and mortality (Andersen & Newman, 1973; Babitsch et al., 2012).

The model has been criticised for the fact that it does not pay attention to cultural dimensions and social interactions (Wilson et al., 2005). Andersen (2008), however, argues that social structure is included in the predisposing characteristic components (Anderson, 2008). Another criticism was the overemphasis of need and at the expense of health beliefs and social structure (Wilson et al., 2005). However, Andersen (2008), argues that need itself is a social construct. This is why need is split into perceived and evaluated.

Another limitation of the model is its emphasis on health care utilisation or adopting health outcomes as a dichotomous factor, present or not present Davidson (2001). Other help-seeking models also consider the type of help source, including informal sources (Davidson, 2001). More recent work has taken help-seeking behaviours further, and more real-world, by including online and other non-face-to-face sources (Davidson, 2001).

Despite the few flaws of the model it has the following strengths; the model considers healthcare utilisation from both the micro (individual) and the macro level (community) level. Predisposing factors clearly explain treatment selection. It includes material, environmental and structural factors, which were barely taken into account in the Health Belief Model. The model is shown in Figure 1.



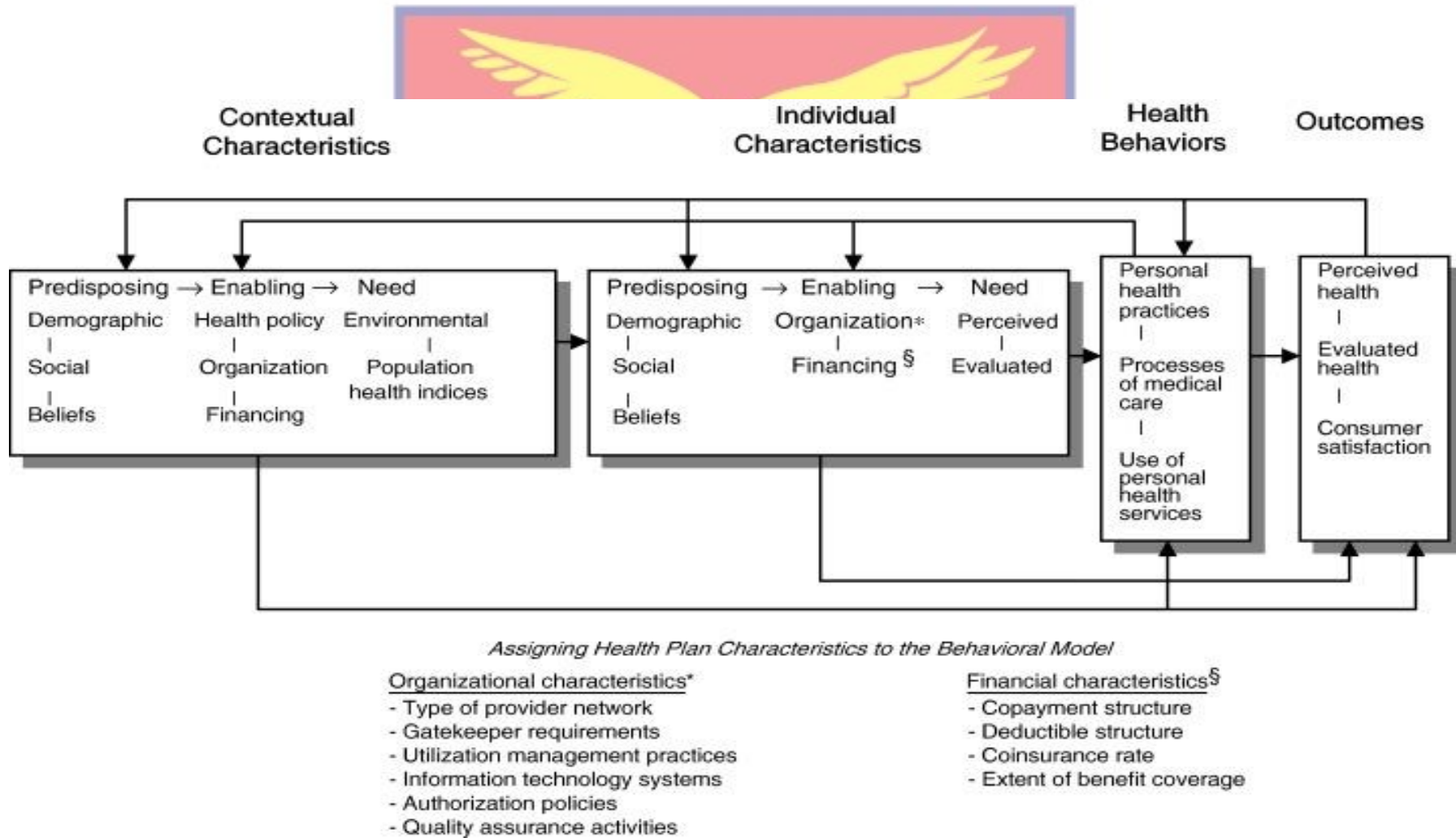


Figure 1: Health Services Utilisation Model

Source: Andersen and Davidson (2001)

### Conceptual Framework of Health Service Utilisation Model

The Health Service Utilisation Model originally propounded by Andersen (1968) but later revised by Andersen and Newman (1973), Andersen (1995), Gelberg, Andersen, and Leake (2000), and Andersen and Davidson (2001), is adapted as the conceptual framework of the study to explain access to healthcare services among SWDs in Ghana. The model was chosen because it is a multilevel theory and as such enables the study to ascertain both contextual and individual predictors of healthcare services among students with disabilities in Ghana. The main tenets of the theory thus, pre-disposing, need, and enabling factors will be the pillars on which the study will be conceptually grounded as these are also in relation to the objectives of the study (Andersen & Newman, 1973). In order to precisely reflect the variables of interest of the study in the adapted model, the framework the variables under each tenant of the model are explained below:

The independent variables for the study are the predisposing factors (sex, age, religion, educational level); the enabling factors, and the need factors. The dependent variable for the study is access to health care services. With regards to predisposing factors, the sex, age, religion and educational level, will be significant in ascertaining the level of utilisation of health services among students with disabilities in Ghana.

Regarding the enabling factors, in this work, they will include both individual and organisational factors, which have to do with access to a regular source of health care. Factors that can enable students with disabilities to access healthcare include; available health personnel, health insurance subscription, available means of transport, affordability of health related



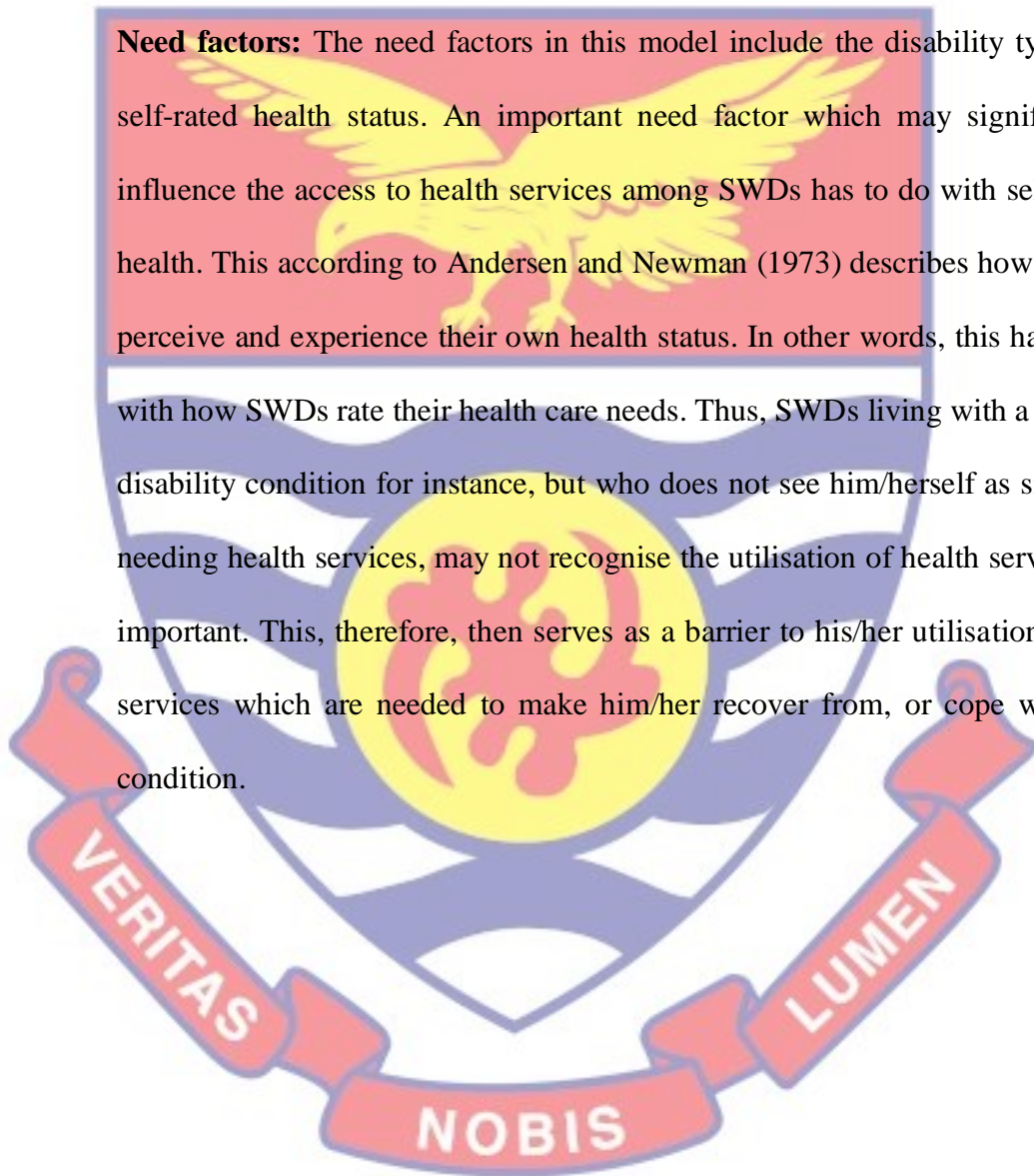
information in the form that the SWDs will comprehend and travel and waiting time at the health facility. Health insurance subscription undoubtedly, is a strong predictor to the utilisation of health care services as this pave way for those who cannot afford the services to access them at a subsidised cost.

As indicated by the model, travel time to a health facility, the means of transportation and waiting time for healthcare are also highly likely to influence the level of utilisation of health care services among students with disabilities. In terms of means of transportation, if there is an easy means by which a student with disability in terms of getting someone to assist him or her to the facility then it is likely to influence the level of utilisation of health care services among students with disabilities. This notion is supported by Thaddeus and Maine (1990). They opined that when the travel time to a health facility is short, the means of transportation is good, and waiting time for healthcare is short, delays that result in the process of utilising care are reduced and this increases eventual client utilisation of health services.

The theory's postulation of organisation at the contextual level which denotes the amount, locations, varieties, structures, and distribution of health personnel and facilities, office hours, hospital and physician density, quality management oversight, provider mix, and education and outreach programmes, point to the preparedness of the healthcare system in offering services to students with disabilities also has the propensity to inform the desire and willingness to for SWDs to utilise such services. For example, if health personnel are not many and do not have basic skills and knowledge on SWDs, and SWDs want to utilise health care services, they have to spend hours in queues just to access care, they may be discouraged from utilising

such services. Policies, for example, the Disability Act 2006 and Article 29 of Ghana's constitution which mandate the health facilities and health personnel to provide healthcare to people with disabilities also constitute organisational contextual enabling factors which may encourage utilisation of services among the SWDs.

**Need factors:** The need factors in this model include the disability type and self-rated health status. An important need factor which may significantly influence the access to health services among SWDs has to do with self-rated health. This according to Andersen and Newman (1973) describes how people perceive and experience their own health status. In other words, this has to do with how SWDs rate their health care needs. Thus, SWDs living with a kind of disability condition for instance, but who does not see him/herself as sick and needing health services, may not recognise the utilisation of health services as important. This, therefore, then serves as a barrier to his/her utilisation of the services which are needed to make him/her recover from, or cope with the condition.



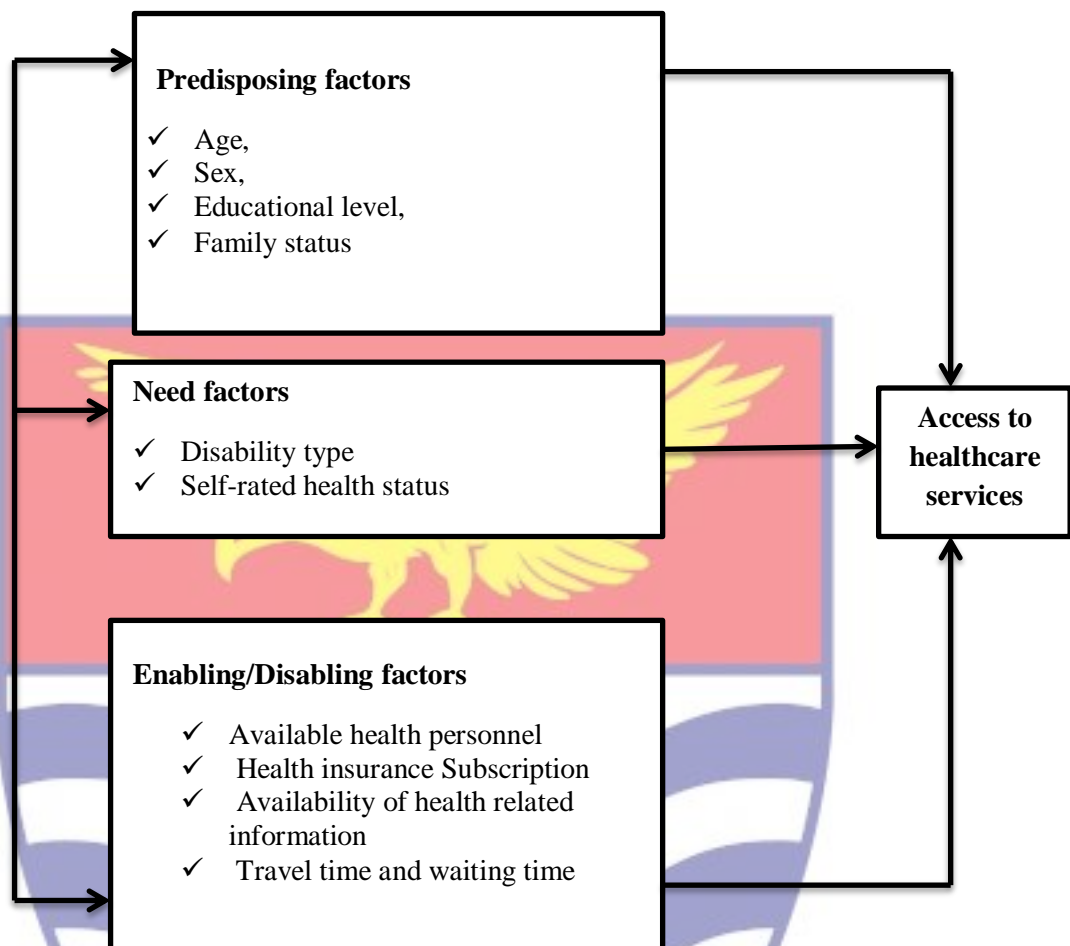


Figure 2: Conceptual Framework

Source: Adapted from Anderson and Newman (1973)

### Empirical Review

This section of the literature review is devoted to reviewing empirically the works done by others which are related to or has bearing on this study. I tried to come out with the similarities and more importantly, the difference between this research and earlier works. I reviewed works of other pervious researchers on the basis of their purpose of study, methodology, findings, recommendations and conclusions.



### Attitudes of Healthcare Providers to Students with Disabilities

In the study of Khan et al. (2016), the purpose/objective of the study was to assess the attitude of medical professionals toward persons with disabilities. Khan et al's study employed cross-sectional purposive survey. As the sample size was made up of 230 medical staff members consisting of doctors and nurses who were selected through the purposive sampling technique. The inclusion criteria were having been between 30 and 50 years, with more than 5 years services working experience. In addition, a self-reported questionnaire was used to gather data by using Interaction with Disabled Persons (IDP) scale. The finding of Khan et al. revealed that all the participants had a mean personal score of 76.74 and standard deviation of 12.02 (n=230) on this questionnaire suggesting that respondents had a more negative attitude towards people with disabilities.

In the research of Sctchidanand et al. (2012), the purpose of their study was to systematically review published studies examining the attitudes of healthcare students and professionals toward patients with physical disabilities. The study employed independent reviewers to complete the selected articles and data abstraction by triplicate review using standardised and pilot tested forms. They resolved disagreements by discussion or with the help of an additional review when necessary. The study used a qualitative approach to identify and report common findings across the studies. The data was analysed qualitatively and reported the result in a narrative way, focusing on common findings that were identified across the study. The findings of this systematic review indicated that both students and professionals in various healthcare fields demonstrate generally favourable attitudes toward patients



with physical disabilities. However, some feelings of fear and discomfort together with a lack of knowledge and experience serving patients with physical disabilities were discovered. Again the study indicated that earlier experience (casual and professional experience) with persons with physical disabilities, previous training in treating patients with physical disabilities, and the female sex were associated with better attitudes among healthcare students and professionals.

Kathleen and Fatata-Hall, (2013), evaluated the change in attitude of nursing students toward children with disabilities over specific time intervals before and after disability education, between the experimental and the control group. The study employed experimental pretest-posttest two group design to evaluate the change in attitude of nursing students toward children with disabilities over specific time intervals before and after disability education, between the experimental and the control group.

Attitudes were measured utilizing the Attitudes towards Disabled Persons scale (ATDP-B) which is the most common valid and reliable tool to measure attitudes in research over the last four decades. Attitude measured were assessed by the researcher utilising repeated measures analysis of variance (ANOVA). Participants for the study were recruited from the senior nursing class in one of the largest private urban universities in the United States that has one of the largest and most respected schools of nursing in the United States. In the study, a sample size of 88 nursing students were chosen consisting of two groups of 44 graduating nursing students in an inner city school of nursing based on historical data from prior graduating registered nursing students. The findings of Kathleen and Fatata-Hall (2013), showed

that the attitudes of nurses toward children with disabilities were significantly more positive after an educational intervention,  $p < 0.0001$ . The statistically significant results of this research support the significance of disability education intervention for nursing students prior to licensure for practice. The results of the multivariate tests for interaction effect of the ATDP-B illustrates

attitudes change over time and after an educational intervention on disabilities. The univariate tests agree with the multivariate approach for within-subject and between subjects' effects of the education intervention. These findings are relevant to this study, since the investigators sought to evaluate the change in attitude of nursing students toward children with disabilities which has a bearing on one of the research questions this study seeks to answer, that is what are the attitudes of healthcare providers towards SWDs?

Based on the findings of Kathleen and Fatata-Hall, the study supported the need for nursing educators to require didactic educational materials and clinical experiences for children with disabilities in the nursing curriculum. The content of these courses must be designed to develop the skills, knowledge, and attitudes needed for nurses in clinical care for children with disabilities. The attitudes of nursing students toward children with disabilities were shown to change significantly in response to the introduction of a 4-hour educational module on the subject of children with disabilities. The study demonstrated the benefits of having nursing faculty members measure the attitudes of nursing students toward children with disabilities as an outcome of nursing education. The results of the research represent a challenge to nursing faculty members to reform nursing curricula to meet the current needs of society.

In the research of Oyewole et al. (2017), the purpose of the study was to evaluate personal attitude towards disability among people with disability. The study investigated self-acceptance and attitude towards disability among PWDs in Nigeria and examined factors influencing their attitudes. The study employed cross-sectional design recruited 260 PWDs consecutively from outpatient clinic of a tertiary hospital in Nigeria. World Health Organization Disability Assessment Schedule (WHODAS 2.0) was used to assess disability among the participants. It is a 12-item version self- or interview-administered that has proved to have good psychometric properties. The Attitudes towards Disabled Persons Form A (ATDP-A) scale was used to assess the attitudes of the participants towards disability.

Also, Oyewole et al's data was analysed using descriptive statistics such as mean, standard deviation, frequency and percentages. Groups' mean differences were assessed using t-test or F-test as appropriate. For categorical variables, association was assessed with  $\chi^2$  test. Poisson regression was used to assess factors that were associated with PWD's attitude towards disability.

Oyewole et al.'s study found that people with disability largely held positive attitudes towards their disability. The positive attitude held by people with disability (PWD) has great advantage not only for the PWD but also for the general public. The results of regression analysis showed that only factors such as educational level, occupation, mild disability, and younger age, type of disability and duration of disability were associated with positive attitude held towards disability among PWD. From the findings, it was also discovered that younger PWDs were 1.04 times more likely to hold positive attitude towards disability compared with older PWDs. Those with mild disability were 1.04



times more likely to have positive attitude towards disability compared with severe disability.

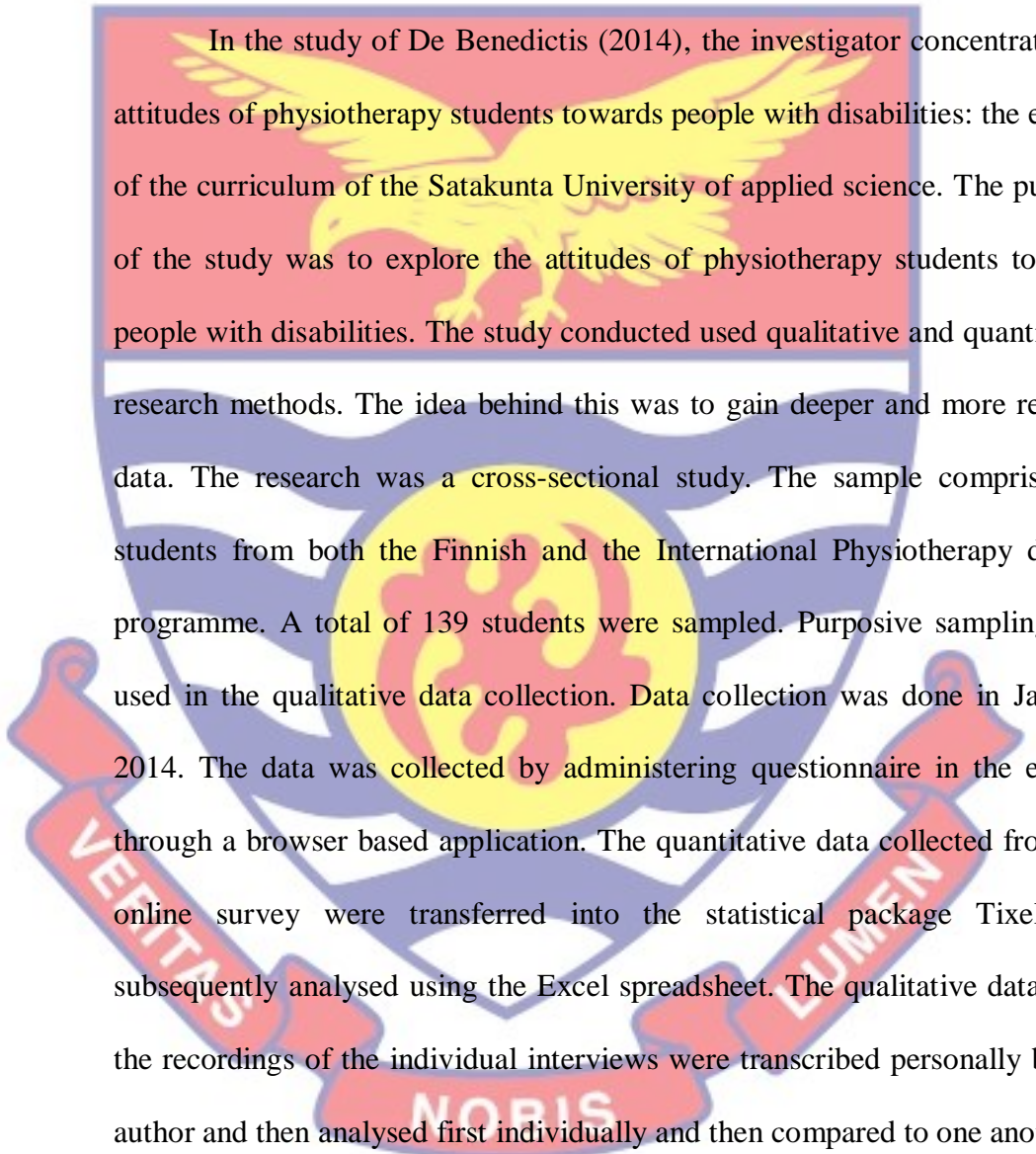
In the study of Masasa, Irwin-Carruthers and Faure (2004), the objective of the study was to assess the knowledge, attitudes and beliefs (KAB) relating to disability held by caregivers of physically disabled children in different cultural groups in the Western Cape. In addition, the study sought to find out how the knowledge, attitudes and beliefs of health care givers might influence the rehabilitation of disabled children. Their purpose of the study which sought to assess the knowledge, attitudes and beliefs (KAB) relating to disability held by caregivers of physically disabled children is related to our second objective which sought to address the attitudes of healthcare providers towards SWDs.

Furthermore, Masasa et al.'s study employed cross-sectional study design. Sixty (60) primary caregivers were interviewed by using a knowledge, attitude and belief (KAB) survey in a structured interview format. Probability and non-probability (systematic and purposive) sampling were used. The study used both quantitative and qualitative methods. It is relevant to this study since this research also employed qualitative method. The study population involved children and their caregivers who attended the physiotherapy departments at the Tygerberg and Red Cross Children's Hospitals in Western Cape, South Africa. Purposive as well as random sampling was used to select 20 caregivers. Again, quantitative data were analysed descriptively and qualitative data were analysed into themes and sub-themes. This research also sought to analyse data into themes and sub-themes.



The findings of Masasa et al. (2004) showed that at least 75% of the respondents felt sorry for disabled people because they struggle, always need help and cannot live a normal life. However, 92% showed that disabled children were not inferior, with only 3% expressing fear of disabled people. All the respondents strongly disagreed with the statement that “families having disabled people should completely hide”, while 97% agreed that “disabled persons should associate with the other members of the community”. Responses on the opinions on the attitudes of society towards people with disabilities were varied, 50% felt that society “did not care”. Eight five (85%) (n=51) agreed strongly that the parents of children with a disability should participate in the treatment of their child and that the child should be taken for treatment once they had been informed that the child was disabled. It was also discovered that although few caregivers were fully informed on the causes of disability, coloured and white caregivers were able to give a wider variety of causes. Many mothers living in sub-economic areas, including informal settlements, do not attend antenatal check-ups, with home delivery of infants being common. Peri-natal and postnatal factors are still frequent causes of neurological disability in the black population. The lack of antenatal care and counselling may not only have resulted in limited knowledge of the causes of disability, but might also delay the identification of disabilities and the subsequent early rehabilitation of infants especially those with potentially minor deficits. In addition, the study found out that most caregivers across all three groups were positive about bringing their child for regular therapy and participating in treatment. From Masasa et al’s. (2004) findings, the following conclusions/ recommendations were made; health professionals need to be

trained to be culture-sensitive and to respect the value systems and beliefs of their clients. In so doing negative attitude towards PWDs can be minimised if not completely eradicated. Professionals also need to advocate and implement disability awareness programmes that will accommodate the viewpoints and expectation of care givers.



In the study of De Benedictis (2014), the investigator concentrated on attitudes of physiotherapy students towards people with disabilities: the effects of the curriculum of the Satakunta University of applied science. The purpose of the study was to explore the attitudes of physiotherapy students towards people with disabilities. The study conducted used qualitative and quantitative research methods. The idea behind this was to gain deeper and more reliable data. The research was a cross-sectional study. The sample comprised of students from both the Finnish and the International Physiotherapy degree programme. A total of 139 students were sampled. Purposive sampling was used in the qualitative data collection. Data collection was done in January 2014. The data was collected by administering questionnaire in the e-form through a browser based application. The quantitative data collected from the online survey were transferred into the statistical package Tixel and subsequently analysed using the Excel spreadsheet. The qualitative data from the recordings of the individual interviews were transcribed personally by the author and then analysed first individually and then compared to one another.

The findings of De Benedictis (2014) showed that when students were asked about the quality of their change in attitudes, all the students pointed out how they never actually thought to have ever held a negative attitude toward people with disabilities.

Nevertheless, when compared to the end of their studies, they all stated that they indeed noticed a valuable change into a more positive attitude, and in the opening of their minds regarding the concept disability. Again, students mentioned how they could not single out a specific factor that has made them change their attitudes into more positive ones, but it was rather the combinations of factors. All interviewees stated that a crucial contributing factor that made their education in SAMK as being so influential in their positive change of attitude, were all the opportunities they were given throughout the years, to closely interact with people with disabilities, in a wide variety of activities.

Arooj, Malik and Siddiqi (2013) conducted a study on professional and personal attitudes of medical students towards disabled persons. The aim of the study was to observe the response of the final year physiotherapy students in Rawalpindi and Islamabad regarding their attitudes towards disabled persons. The study was a cross sectional study and recruited 82 final year physiotherapy students through purposive sampling techniques. Form 'A' of ATDP-A, was used to assess attitude toward the disabled persons. The ATDP-A contains 30 items presented in a five point Likert format, with response ranging from strongly disagree to strongly agree. Total score may range from 0-180, with high scores reflecting positive and low score reflecting negative attitude. The ATDP-A took 15 minutes to complete. One copy of the ATDP-A was distributed to each of the students and they were divided into two equal groups of 20. Group one was asked to complete the scale according to their professional views only. Subjects in group two were asked to respond with their personal views only. As soon as the groups had responded as requested,



the procedure was reversed, with group two being asked for professional responses and group one for personal views. This reversal procedure was used to balance for order effect. The study found that the personal attitude of final year students were significantly more positive than the professional attitude as measured by the form “A” of ATDP scale. This means that senior physiotherapy students can dissociate personal from professional attitude. On the basis of the above finding, the investigators recommended that there is need of change in curriculum like disability-oriented workshop, session with disabled persons and interactive discussion forum.

Al-Abdulwahab and Al-Gain (2003) conducted a research entitled attitudes of Saudi Arabian health care professionals towards people with physical disabilities. The main objective of this study was to characterise the attitudes of Saudi Arabian health care professionals towards people with physical disabilities and to determine the relationships between attitude and age and working experience. Scale of Attitudes towards Disabled Persons (SADP) was personally distributed among a sample of 130 Saudi health care professionals in four hospitals, including King Fasal Specialist Hospital and Research Centre, King Kalid University Hospital, King Fahad National Guard Hospital and Security Forces Hospital in Riyadh city. All participants worked with various types of disabilities including physical disabilities. Descriptive statistics, Kruskal-Wallis and Spearman's correlation coefficient tests were used to analyse the data of this study with alpha level 0.05, using the SPSS statistical programme. It was revealed from the study that the participants exhibited positive attitudes towards physically disabled people with mean score of  $100 \pm 17$ . Attitudes among health care professionals were not



significantly different ( $p < 0.40$ ). Educational degrees showed no significant effect on attitudes of participants towards people with disabilities ( $p < 0.45$ ). A poor relationship was found between attitude scores and both age ( $r = 0.03$ ) and experience ( $r = 0.003$ ). The researchers concluded that Saudi Arabian health care professionals displayed positive attitudes towards people with disability as do other health care professionals worldwide. This may indicate that cultural values, traditional beliefs, educational environment and religion have little effect on attitudes of health care professionals.

In conclusion, the above empirical review literatures outlined issues pertaining to attitude of healthcare professionals towards persons living with disabilities. The works of Khan et al., (2016), Sctchidanand et al., (2012), Kathleem and Fatata-Hall (2013) employed quantitative studies whereas Oyewole et al., (2017) used cross-sectional design, but in my study, I employed qualitative research design dwelling on the phenomenological approach and used interview to collect data. This helped to better understand from the subscribers (SWDs) how challenging it is when it comes to access to healthcare services from the various hospitals they seek healthcare services. In Khan et al's study they employed questionnaire as a data collection instrument which to some extent might restrict the researchers from exploring adequately the attitude of the healthcare providers towards persons with disabilities. But in my study I employed interview for both the SWDs and the healthcare providers. I believe with the use of interview I was able to explore indepth revelation with regards to the topic being researched into. Similarly, in the work of Sctchidanand et al., they only did systematic review published studies examining the attitudes of healthcare students and professionals toward

patients with physical disabilities. Their study only used one category of disabilities that is physically disabled to the neglect of the many whose healthcare is also important. My study looked beyond only the physically impaired by considering the hearing impaired, visually impaired and the intellectually disabled. Setchidanand et al., depended solely on existing literature which could have been old and possibly outmoded and therefore cannot be used to draw conclusions and judgement, however, my study used indepth interview to elicit the views of the participants to ascertain the ideas and perception underpinning access to healthcare services among SWDs. Finally, the above studies concentrated mostly on adult with disabilities but in my studies I looked at the students with disabilities dwelling on basic special schools in Ghana.

### **Physical Accessibility of Healthcare Facilities**

Despite UNCRPD requirements that health care providers ensure equal access to programmes, services, and facilities for people with disabilities, physical accessibility remains a huge challenge. One of the most obvious challenges for people with physical disabilities is overcoming the barriers to entering, moving and exiting health care facilities. These challenges include inaccessible entrances, hallways, examination rooms, medical equipment, and restrooms.

This back drop buttresses the work of Singer, Dickman and Rosenfeld (2017), where the purpose of their study was to find out why physical accessibility of health care facilities is important for people with disabilities. Again, the study discussed the laws enacted to promote accessibility and provides examples of federal and state-level efforts to increase accessibility,

and finally, the study sought to offer suggestions for improving physical accessibility of health care facilities on a broader scale. The findings of the study revealed that inaccessibility of provider offices and medical facilities is an important contributing factor to the wide health care disparities experienced by people with disabilities. Structural obstacles, inaccessible medical equipment, and restrictive policies and procedures can render basic and specialty health services inaccessible and can result in negative care experiences and/or delays in seeking necessary care for this population.

Afio, De Carvalho, Marques, De Oliveira, De Almeida and Pagliuca (2016) conducted a research on physical accessibility for disabled people in primary health care units in Brazil. The study aimed to analyse the physical accessibility of toilet facilities in urban and rural primary health care units. The research was a quantitative descriptive study conducted in 157 Primary Health Care Units of 16 municipalities in the Baturite Massif region, Ceara, Brazil. The study took place from August 2014 to May 2015, with a checklist type form, designed from the Technical Standard 9050 of the Brazilian National Standards Organization, specifying the ideal access conditions established by law to allow mobility of persons with physical disabilities. The instrument was structured in two parts, the first relating to the unit's identification data and the second containing topics on the characteristics of the various sectors that constitute the physical structure of health service units, particularly analysing the topic toilet facilities with the following items: location; signs; use for both sexes; doorway width; wheelchair maneuvering areas (forward, 90<sup>0</sup>, 180<sup>0</sup>, and 360<sup>0</sup> rotation, and free space); grab bars; toilet seats; toilet paper dispensers; flush control; sink and faucet. Response options



were: Accessible (A), accessible structure; Inaccessible (I), inaccessible structure; Absence (AB), without the structure to be evaluated; Does not apply (DNA), the place did not require the structure; Renovation (RE), rooms being renovated; Not Collected (NC), place closed at the time of collection; and Without the Place (WP), the location to be assessed did not exist. During data

collection, materials such as measuring tapes and digital cameras were used, and all the survey participants were trained for proper filling of the instrument and correct use of support materials. Data obtained were entered into spreadsheet, through Microsoft Excel, in two databases in order to avoid any typing errors. For data analysis, the Statistical Package for the Social Sciences (SPSS) software version 20.0 was used, and data were later presented in tables with absolute and relative frequencies. The Binomial test was applied to compare the variables Accessible and Inaccessible, Chi-square test to assess the association between the variables of interest, and Odds Ratio (OR) to measure the magnitude of the effect, adopting a 95% confidence interval (95% CI). The level of statistical significance was set at 5% ( $p < 0.05$ ).

The results from the study discovered that toilet facilities were accessible as the location and signs, with statistically significant differences ( $p < 0.001$  and  $0.010$ , respectively). Regarding the separation of bathrooms by gender, it was found that 57.3% were divided into male and female. Of all toilet facilities, 77.7% have inaccessible doorways ( $p < 0.001$ ), despite presenting space to perform the 1.20 m forward approach ( $p = 0.006$ ). Nonetheless, in absolute majority, there were no obstacle-free space for maneuvering the wheelchair in  $90^\circ$ ,  $180^\circ$  and  $360^\circ$ , thus being considered inaccessible ( $p < 0.001$ ). Regarding the presence of horizontal bars on the side



and rear walls, 67.6% were allocated inappropriately or non-existent, constituting the inaccessibility of this item with significant results ( $p = 0.019$ ). Toilet seats and toilet paper dispensers were evaluated mostly as inaccessible to the physically disabled ( $p < 0.001$ ), considering they did not contain accessibility aspects, like appropriate height. Flush controls, however, were considered accessible as the height and activation by light pressure ( $p = 0.002$  and  $0.006$ , respectively). Sinks presented accessibility aspects, such as the absence of pedestals (51%), but the height and faucet type were inadequate ( $p = 0.000$ ). The study concluded that access to primary healthcare facilities to disabled persons was still incipient, since architectural barriers are easily observed in health care services, constituting obstacles to health care.

Badu (2014) conducted a study on the topic “healthcare accessibility barriers confronting persons with disabilities in the Kumasi Metropolis”. The study aimed at assessing the extent of healthcare accessibility barriers that persons with disabilities are confronted with. Specifically, the study sought to; examine the nature of healthcare barriers confronting people with disabilities, assess differences in access among various socio-demographic groups of people with disabilities, to measure the extent to which barriers affect the healthcare utilisation among people with disabilities, assess the effect of financial accessibility on healthcare of people with disabilities and to identify healthcare needs of persons with disabilities.

The study employed a cross-sectional design to assess healthcare accessibility barriers confronting PWDs in the Kumasi metropolis. The study’s population comprised disabled males and females such as the hearing impaired, the visually impaired and physically challenged persons aged 15

years and above in the Kumasi metropolis. Participants were PWDs who accessed healthcare in the Kumasi Metropolis since the main focus of this study was on their experiences as they utilise the services. The sample size for the study was 255 which was selected through the multi-stage sampling technique and were selected from 5 communities in the Kumasi Metropolis namely; Oforikrom, Asawase, Subin, Tafo and Asokwa. Data was collected by the use of a written interview through structured questionnaire.

Result of the analysis was generated using descriptive and analytical statistics. Data were summarised in the form of frequency and percentage tables for categorical variables. Means, minimum, maximum, standard deviation and graphs were also used to summarize continuous variables. Chi-square tests were used to test for significance of associations between the independents and outcome variables. Student t-test was also used to test for significance of associations between the predictor and outcome variables. Linear regression analysis was used to determine predictor variables that are associated with expenditure on healthcare for a month. Significance was set at  $p$ -value of less than 0.05. Results showed that although respondents faced physical, communication and medical equipment barriers to healthcare, those with physical and communication barriers had significant relationship with access to the healthcare ( $p=0.018$ ;  $p=0.001$ ) whereas those with medical equipment barriers had no significant relationship ( $p>0.005$ ). The NHIS was used by most respondents as source of payment for healthcare as it had a significant relationship with access to the services ( $p=0.000$ ), although, it does not cover equipment and other expenses.

It was then concluded that persons with disabilities were mostly unemployed and had no formal education. Demographic factors such as age, community of resident and whether a PWD stayed with the family member increased the likelihood of access to healthcare. Factors such as gender, religion, employment status and educational qualification however had no significant relationship with access to healthcare among PWDs. On the nature of healthcare barriers among persons with disabilities, it was revealed that PWDs in Kumasi Metropolis indeed, faced barriers to healthcare including physical barriers, medical equipment and communication. Examples of physical barriers cited include inaccessible door entrances, inaccessible staircases, and absence of elevators, absence of ramps and medical labels and inaccessible tiles on the grounds for patients using crouches.

Although NHIS was most cited source of financing healthcare, however, it does not cover all expenses and other suppliers' coverage. In spite of the barriers, PWDs turned on supports from their personal assistant such as family members, friends or caregivers and hospital professionals. With respect to the extent to which barriers affect the utilisation of healthcare of PWDs, the results found out that the majority of PWDs do not receive the expected healthcare, although, they reported relative good services offered them. It can be concluded from the study that PWDs refuse to admit when they are in health problems or deficiency because of the fear of healthcare expenses, lack of communication access and discrimination. Persons with disabilities who faced physical and communication barriers had significant relationship with care. However, those with medical equipment barriers had no significant relationship with healthcare. In addition, it was found that considering



financial barriers, healthcare utilisation among PWDs in Kumasi Metropolis was influenced by the amount they pay for transportation and the travelling distance to healthcare centres. Access is however higher among those who pay GHC 2.00 to 5.00 and travel between 15 to 30 minutes.

The study again discovered that most PWDs in Kumasi Metropolis are enrolled in NHIS as sources of payment for healthcare, however, all equipment and suppliers of their healthcare are not covered such that they pay on average GHC 21.46 per month to cover them. With cost of food and shelter consuming the highest portion of PWDs income, it will affect other essential sectors of their life such as healthcare, education and social protection. Finally, on the healthcare needs of persons with disabilities, it was shown that PWDs with communication difficulties in Kumasi Metropolis needs provisions such as availability of qualified sign language interpreters to ensure communication between doctors, instructions for physical examinations and drugs, the need for braille format text for drug prescription and other medications and use of assistive listening devices. The study further concludes that PWDs need sponsorship that could cover all expenses, transportation to healthcare centres particularly for physically challenged patients such as wheelchair and amputee, specialist doctors and regular check-ups.

On the basis of the findings of this study, the researcher made recommendations to the government, Kumasi metropolitan health service providers and management and NGOs and other stakeholders. In his recommendations to the government, it was recommended that the Government through its ministries such as health and housing ministries needs

to re-visit existing building regulations and policies to re-design buildings to ensure a more disability friendly healthcare structures that will be accessible.

Moreover, it was the ministry of health in collaboration with the education ministry should make it an intervention priority to train sign language interpreters to fill all healthcare centres throughout the country.

When this is done, it will help to overcome the communication difficulties that PWDs face in accessing the services.

In addition, it was recommended that service providers should also be educated with basic signing to ensure they can at least communicate to patients with such difficulties when there is no qualified sign language interpreter. This will remove the communication barriers arising out of lack of sign language interpreters. In the same direction, it was recommended that the ministry of health should re-visit the NHIS policy to make it cover all expenses of PWDs healthcare such that equipment and other suppliers are covered to remove financial barriers in accessing healthcare as reported in this study. For the recommendations to the Kumasi Metropolitan Health service providers and management, he recommended that; the health service providers and management in the Metropolis need to ensure that all equipment used at service centres are accessible to all PWDs and that the equipment is regularly maintained. He also added that information should be made available to PWDs to identify the nearest healthcare since distance and time were one of the key influences on access to healthcare. This information should equally provide the specific services offered by healthcare centres. This can be achieved by using the media through local radio and television to promote and education campaign. In line with that, he recommended that persons with disabilities in

Kumasi Metropolis should be given proper healthcare education and promotion so as to change their health seeking behaviour that influence them not to admit when they are in health problems with the fear of medical equipment barriers, discrimination, and cost involved in obtaining the services. Finally, he recommended that there should be schedule for training and in-

service training organised for service providers to always update their knowledge on disability issues. For the NGOs and other stakeholders, it was recommended that International or Local Donors focusing on healthcare need to target PWDs to supplement the efforts of the Government and health professionals in Kumasi Metropolis. The effort of NGOs could be achieved through promotion of community-based educators on health seeking behaviours of the disabled and specific service centres as well as specialist in Kumasi Metropolis. The NGOs should again assist to enroll PWDs into the NHIS either through payment of subscription fee or educating them about the programme.

Badu, Agyei-Baffour and Opoku (2016) conducted a research on the topic “access barriers to health care among people with disabilities in the Kumasi Metropolis of Ghana”. This study aimed at contributing to filling the evidence gaps on access barriers to healthcare among people with disabilities in the Kumasi Metropolis in Ghana. A cross-sectional design was used. Quantitative data collection method was employed to conduct the study with persons living with disabilities in the Kumasi Metropolis as population target. The sample size was then estimated at 255 people with disabilities using Cochran’s sample size formula. The study used a multi-stage sampling to randomly select communities in the Kumasi Metropolis. Five out of ten



clusters based on definition of sub-metro were selected: Oforikrom, Subin, Asawase, Tafo and Asokwa. In each of the selected communities, simple random sampling was used to select people with disabilities (physically challenged, hearing and visually impaired).

The research team zoned households and streets in selected communities and all people with disabilities were approached and then made to pick from a box with papers written on them “Yes” and “No”. All people with disabilities who picked “Yes” in all the clusters and consented were enrolled. This was repeated until the required sample size was achieved. In all, 51 persons with disabilities were selected from each cluster to get a total sample of two hundred and fifty-five (255) respondents. The researchers used structured questionnaires to collect information from the respondents. The questionnaire was developed in English but was administered in the respondents’ preferred dialect; English, Sign language or Asante Twi.

A professional interpreter volunteered to assist in the study. The data was collected over a period of two months to allow time to reach all respondents. Each participant spent approximately, 40 minutes answering the questions. Questions were asked around background characteristics and issues on access barriers to healthcare. Background information consisted of community of resident, age, gender, occupation, education, religion and whether people with disabilities were staying with their family members. Questions on access barriers were related to whether people with disabilities faced physical, communication, and medical equipment barriers to healthcare. The questions were further asked around the type of physical, communication and medical equipment barriers and support for communication difficulties.

The results of the analysis were generated using descriptive and regression statistics. The data obtained from the respondents was first estimated by considering the percentage distribution. The socio-demographic characteristics such as age, community of residents, marital status, education, employment and family status were estimated. Also, percentage distribution of potential access barriers like physical, communication, medical equipment was also estimated. Logistics regression analysis reporting odds ratio was estimated with different type of access barriers as dependant variables.

Independent variables in the regression were disability type, age, education, employment type, geographic location, religion and living arrangement. Significance was set at p-value of less than 0.05. The data obtained from the field were first entered into Statistical Package for Social Sciences Software 20 and transported to STATA version 14 for analysis. The study found that most people with disabilities had no formal education. Similarly, people with disabilities with no formal employment were most prevalent. The study found that people with disabilities faced barriers to health care including physical, medical equipment and communication. For instance, the physical barriers were inaccessible door entrances, inaccessible staircases, absence of elevators, absence of ramps, medical labels and inaccessible floors for patients using crouches as floors were tiled. Furthermore, the study found out that lack of readable signs and difficulty in following equipment instructions were the most reported barrier to medical equipment followed by inaccessible high beds, tables and chairs. Moreover, the study found that females were the group more likely to have experienced physical barriers to healthcare and less likely to experience communication barriers.

The study again found that people with disabilities who were in their forties and above were more likely to have experienced physical and medical equipment barriers to healthcare. Respondents with some education were more likely to have experienced physical barriers. This finding implies that respondents who were educated knew their basic right to health care and could identify what is regarded as barriers. Finally, it was revealed that people with disabilities who were not staying with their family members were more likely to have experienced physical and communication barriers to health care. This finding implies that when a disabled person stays with a family member there is the likelihood of the family member providing support at the health facility to reduce the barriers. The support that the disabled person may receive from the family member or caregiver is likely to improve access to health care. Specifically, the study found that people with disabilities get support to medical equipment through caregivers and health professionals.

Vergunst (2016), concentrated on access to health care for persons with disabilities in rural Madwaleni, Eastern Cape, South Africa. The study explores the challenges faced by persons with disabilities in day-to-day living and in accessing health care in Madwaleni, a rural isiXhosa-speaking community in South Africa. The study was a quantitative survey. The researcher interviewed 773 participants in 527 households. Comparisons between persons with disabilities and persons with no disabilities were explored. Data for the study were collected in the Madwaleni area in October-November 2011. A total of 17 data collectors were trained by members of the equitable research team for a week before spending three weeks in the field collecting data using mobile phone technology. Local chiefs of the area were



contacted and told about the study and they all gave the researcher access to their communities.

The study employed three interviews and three questionnaires depending on the circumstances. Data collectors were local community health workers from the area and were aware of the dynamics of the community. The approach to data analysis for this study included quantitative data analysis using descriptive and inferential statistics. Frequency and cross tabulation, comparing and contrasting the frequency of different phenomena between persons with disabilities and persons with no disabilities were used. Chi-squared tests (comparison by percentages) and Analysis of Variance (ANOVA) tests (comparison by means) were then incorporated into the analysis.

Results suggest that persons with disabilities in Madwaleni generally experience more problems in terms of daily living as well as health issues (including access to health care) compared to persons with no disabilities. In terms of access to health care there were primarily three types of barriers namely; physical barriers, attitudinal barriers and communication barriers for persons with disabilities in Madwaleni. Persons without disabilities living in households with persons with disabilities did not, however, experience more barriers to health care than did those in households without disabilities.

Ganle et al. (2016) conducted a qualitative research on challenges women with disability face in accessing and using maternal healthcare services in Ghana. The aim of this study was to explore the challenges women with disabilities encounter in accessing and using institutional maternal healthcare services in Ghana. This qualitative study was conducted in 27 rural

and urban communities in the Bosomtwe and Central Gonja districts of Ghana with a total of 72 purposively sampled women with different physical, visual, and hearing impairments who were either lactating or pregnant at the time of this research. Semi-structured in-depth interviews were used to gather data. Attride-Stirling's thematic network framework was used to analyse the data.

The research was conducted in 27 communities (19 rural and 8 urban) in the Bosomtwe and Central Gonja districts of the Ashanti and Northern regions of Ghana respectively. These two districts were purposively selected to represent northern and southern Ghana in the study. The researchers purposively sampled 72 women with different physical, visual, speech and hearing impairments who were either lactating or pregnant at the time of this research (November 2012 to May 2015). They excluded women with intellectual disabilities partly because of the complexities involved in assessing mental disability and partly because of the research team's limited knowledge in undertaking such assessment. The women included in the study were identified through screening. An adapted screening tool from the Washington Group on Disability Statistics was used. This screening tool has been successfully used in other low-income contexts to screen and identify women with disabilities. The tool has 35 questions to detect epilepsy, physical, sensory, behavioural, and social function and communication disabilities based on the International Classification of Functioning, Disability and Health (ICF). The screening tool captures severity of disability by asking respondents to rank their status on a four-point Likert scale.

To facilitate easy understanding by participants, the screening tool was translated into the three dominant local dialects—Twi, Dagbani and Gonja of the study communities. Women were screened at different locations, including their homes, healthcare facilities, market places, and churches/mosques. The recruitment process continued until saturation was attained in the data. Community-based surveillance volunteers were recruited and trained to help with the screening and conduct of interviews. These are community members who have been recruited and trained by the Ghana Health Service in various aspects of community health, including but not limited to reporting the outbreak of diseases as well as births and deaths in their communities. Semi-structured in-depth interviews were used to collect data. A semi-structured interview guide was first developed by one of the research team members who has extensive experience in working with persons with disability in Ghana. The guide was developed in consultation with women with disabilities. All the research team members then reviewed and agreed on the final interview guide.

Majority of the interviews were conducted in the local dialects—Twi (in Bosomtwe District), and Dagbani and Gonja (in Central Gonja District). A few were done in English. Interviews lasted 1 hour to 1 hour 30 minutes. Typically, interviews first captured basic socio-demographic characteristics of participants such as age, level of education, and type of impairment. Interviews then focused on exploring the women's experiences of pregnancy and childbirth, their desire for children, and their experiences with the health service. Interviews also explored how their disability had affected the maternal healthcare and support they had received in the health facility. Both open and closed ended questions were asked. For women with speech and hearing



impairments, interviews were conducted with the help of the community-based surveillance volunteers, family and friends.

Data were recorded and transcribed, and all non-English transcripts were translated into English. Three independent bilingual specialists each checked the quality of translations from Twi, Dagbani and Gonja to English.

All transcripts were exported into Nvivo where coding, categorisation and theme identification were done. Data were analysed using Attride-Stirling's thematic network analysis framework. The Attride-Stirling thematic network analysis framework provides a technique for breaking up qualitative or textual data, and for performing micro-analysis to show how the structure of talk in field interviews and discussions is connected or disconnected. The framework also allows for open and methodical discovery of emergent concepts and themes and their interconnections. Where appropriate, verbatim quotations from interview transcripts were used to illustrate relevant themes. In reporting the findings, the researchers followed the consolidated criteria for reporting qualitative research. Findings from this study revealed that although women with disability do want to receive institutional maternal healthcare, they often encounter challenges related to mobility and the use of public transport services as well as access to health facilities. Healthcare providers' insensitivity and lack of knowledge about the maternity care needs of women with disability, and health information that lacks specificity in terms of addressing the unique maternity care needs of such women also emerged as a key challenge to these women's access to maternal healthcare.

In summary, the works of Afio et al.,(2016), Vergunst (2016) and Ganle et al., (2016) were with regards to physical accessibility of healthcare facilities which is in connection with one of the research questions in this study that is how accessible are the physical structures of the healthcare facilities to SWDs. However, Ganle et al., (2016) employed qualitative research design while Afio et al., (2016) and Vergunst (2016) employed quantitative research design. In the current study, I employed qualitative design drawing on phenomenological approach. Afio et al and Vergunst failed to state categorically the sampling procedure that was used in the selection of the sample size.

#### **Financing Healthcare among Students with Disabilities**

According to World Health Survey (2002, 2004) affordability was the primary reason why people with disabilities, across gender and age groups, did not receive needed health care in low-income countries. In 51 countries where the survey was done indicated that 32–33% of nondisabled men and women cannot afford health care, compared with 51–53% of people with disabilities. Transport costs also rank high as a barrier to health care access in low-income and high-income countries, and across gender and age groups. Health services are funded through a variety. Health services are funded through a variety of sources including government budgets, social, insurance, private health insurance, external donor funding, and private sources including nongovernmental arrangements and out-pocket expenses. In spite of this assertions by WHO, not much work has been done.

However, Badu, Opoku, Appiah and Agyei-Okyere (2015) conduct a research on financial access to healthcare among persons with disabilities in Kumasi Metropolis, Ghana. A cross-sectional design with quantitative data collection method was employed for the study. The study enrolled a total of 255 persons with disabilities - physically challenged, hearing and visually impaired. Multi-stage sampling was used to randomly select 5 out of 10 clusters of communities based on the definition of sub-metro, including Oforikrom, Subin, Asokwa, Tafo and Asawase. The investigator and the research team also used simple random sampling to select participants who were from these communities. Persons with disabilities in all the clusters were made to pick from a box which had papers with either “Yes” or “No” written on them. All those who picked a “Yes” and gave their consent were enrolled. This was repeated to obtain the required sample size. In each cluster, a snowballing technique was also used to zone households and streets in selected communities. The aim and procedures of the study were explained to all the persons with disabilities who were approached, and they were free to decide whether or not to participate. The inclusion was partly based on those who were accessible and could provide information on the topic of interest. A structured questionnaire was administered to respondents. The questions focused on background characteristics and issues pertaining to financial access to care. Background information included the community of residence, age, gender, occupation, education, religion and whether they were living with their family members. Questions on financial access related to the time it takes persons with disabilities to reach the facility, transportation, monthly expenditure on care, sources of payment and the coverage of expenses. The



inclusion criteria included persons with disabilities of age 16 years and above, who stayed in the study area and accessed healthcare in the last 12 months within the metropolis. The questionnaire was developed in English but administered in the respondents' preferred dialect - English, Sign language or Asante Twi. A professional interpreter volunteered to assist in the study. Prior to implementation, the Principal Investigator (PI) organised a two-day training on the study tools, for two research assistants who were studying MPhil Sociology and MSc Disability, Rehabilitation and Development. The PI along with the two research assistants conducted the field work. The data was collected over a period of two months (February–March, 2014) to allow time to reach all participants. However, each participant spent approximately 40 minutes to answer the questions.

Results of the analysis were generated using descriptive and analytical statistics. Data analysis involved the estimation of percentage of socio-demographic characteristics of respondents. The distribution of factors pertaining to financial access to healthcare, including the time taken to reach the facility, amount spent on transportation, monthly expenditure on healthcare, regular source of healthcare and payment, were again estimated using percentages and frequency. The analyses of association between financial access and healthcare access were estimated using the Chi-square tests of significance of association. In addition, One-Way ANOVA was used to compare mean monthly expenditure on health among various socio-demographic characteristics of respondents. Significance was set at p-value of less than 0.05.

The study found that there were more male than female participants, nearly one-third of them had no formal education and 28.6% were unemployed. The average monthly expenditure on healthcare was GHC 21.46 (USD 6.0) which constituted 9.8% of the respondents' income. Factors such as age, gender, disability type, education, employment, and whether or not they stayed with family members had significant bearing on the average monthly expenses on healthcare ( $p < 0.05$ ). Transportation cost, the travel distance to facilities, and the regular sources of payment for healthcare, had significant relationship with access to healthcare ( $p < 0.05$ ). Although about 63.5% of the respondents used the National Health Insurance Scheme as the regular source of payment for healthcare, 94.1% reported that sources of payment did not cover all their expenses and equipment.

The researchers recommended that to ensure that persons with disabilities enjoy financial risk protection; the Ministry of Health in Ghana should amend the NHIS policy and make it cover all the healthcare expenses of persons with disabilities without reservation. This would help to remove financial barriers to healthcare among persons with disabilities. Also, major stakeholders including social networks should assist in enrolling persons with disabilities into the NHIS, either through payment of subscription fee or by educating them about the programme.

Ervin and Merrick (2014) reviewed literature on intellectual and developmental disability. The researchers decided to pay attention to areas such as; financing healthcare for this population and new and emerging models. The authors certain chronic conditions that are found among people with intellectual and developmental disability that are known drivers of

healthcare costs. They added that while these challenges are recognised to delivering high-quality and affordable, sustainable healthcare to people with intellectual and developmental disability, it must also be acknowledged that obstacles to accessing the level of care required of these particular circumstances persist and contribute to a higher cost of healthcare. For the new and emerging trends, the review found that models that address the costs of healthcare for people with intellectual and developmental disability, while achieving high-quality care and outcomes are emerging. States and practitioners alike are recognising the need to change systems of care and, importantly, people with intellectual and developmental disability and their advocates are pushing for greater access with better out-comes. It was concluded that the high cost of healthcare for people with intellectual and developmental disability is not new. People with intellectual and developmental disability are far more likely than their typically developing peers to experience health disparities, disproportionately higher rates of chronic disease, and less access to preventative primary care and health promotion resources. The result is that people with intellectual and developmental disability tend to access the healthcare system at a point when care and treatment will be more extensive and therefore costly.

In summary, even though, not much work has been done in the field of financial constraints faced by persons living with disabilities in accessing healthcare; however, WHO report, Badu et al, 2015 and, Ervin and Marrick, 2014, works on how persons with disabilities get financial support for their healthcare services access have been reviewed above. Badu et al and, Ervin and Merrick study employed cross sectional quantitative study. In my work I



employed qualitative research design using interview to collect data from the respondents in order to ascertain how financing healthcare services by SWDs and how it affects the quality of healthcare services received. Again, Badu et al, concentrated on adults living with disabilities in the Kumasi Metropolis to the neglect of SWDs with disabilities in the special schools, therefore my study sought to bring to bear the how SWDs fund their healthcare services.

### **Available Support Services at Healthcare Centres**

Cupples, Hart, Johnston and Jackson (2012) conducted a research on improving healthcare access for people with visual impairment and blindness. The aim of the study was to find out the support services provided for people with visual impairment in the United Kingdom. The study was a qualitative study where five visually impaired persons were selected and interviewed through purposive sampling technique. The data that was collected were grouped under three themes namely; improving delivery of information and treatment, helping patients to navigate unfamiliar environments and communication and consultancy skills. Paying attention to the first theme, it was revealed that when dealing with visually impaired persons, the care givers considered carefully how to share information appropriately with the patient, family, and points of referral.

Depending on the patient's level of disability appropriate communication might comprise sending letters in large print, with different font styles, or with background contrast, or offering information in audio format, by telephone, or electronically (email or compact disc), rather than letter. For a very few profoundly affected individuals, braille letters or information could be needed. Patients should be asked about their supporting

network of family or friends and how this can be employed in assisting with their healthcare needs. For the second theme, it was discovered that furniture placement and style, lighting levels, glare reduction, use of contrasting colours, and tactile and dual audio and visual signage are important considerations in improving access. It was also portrayed that if patients cannot read signs or observe others they may have difficulty finding their way around healthcare premises. They might not be able to communicate effectively with staff because they cannot see visual cues, gestures, or facial expressions. As clinics and surgeries adopt electronic systems to summon patients, visually impaired patients may find that they miss their slots because they are not called. Healthcare staff should be alert to recognise those for whom electronic systems, particularly those with visual instructions only, pose problems. In a clinic situation, the health care providers come out to the waiting room to call the patient and guide them to the consulting room if necessary. They also use accurate and specific language when giving directions or explaining the layout of a room. On the last theme, the research found that writing clear information in referrals about needs relating to vision, and flagging records for future visits facilitates access to good quality care. Good communication empowers patients and enhances their contribution concordant management. In summary, even though not much works have been done in the area of available support services for the SWDs in our various healthcare facilities, nevertheless, the work of Cupples et al., (2012), aimed at researching on support services provided for people with visual impaired, employing qualitative approach.

In this research work, I looked at available support services for SWDs using in-depth interview to assess from both healthcare providers and SWDs to ascertain the availability of support services in our various healthcare facilities to SWDs.





## CHAPTER THREE

### RESEARCH METHODS

#### Introduction

This chapter presents an overview of the methods used in the study. Areas covered include the research design, population, the research instruments, data collection procedure and data analysis procedure, pilot testing of data collection instrument and ethical consideration.

#### Research Design

I employed a qualitative research design for the study, drawing on phenomenology as a research paradigm. This argues that research problems and its scope must lead the methodology (Shimahara, 2013). Phenomenological research attempts to understand the essence of the phenomenon of interest and ensures in-depth understanding of the issues (Creswell, 2007).

Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world (Merriam, 2009). As such, the study delved into assessing the barriers that SWDs face in accessing health services in special schools. This enabled dialogue and listening to capture the essence of what is perceived by subjects (Vander, 1999).

According to Denzin and Lincoln (2005), qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices

transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them. Therefore, I employed qualitative approach to this research to critically examine how SWDs access healthcare services. I wanted to understand from their point of view how challenging it is when considering access to healthcare services. With this approach I could better appreciate their point of view on the issue of healthcare service.

### **Population**

A population in a research refers to the larger group of people with common observable features to which one hopes to apply the research results (Fraenkel & Wallen, 2003). According to Neuman (2007), population is the unit being sampled, the geographical location, and the temporary boundaries.

It can be a person, organisation, a written document or a social action. The population of this study were SWDs, that is, intellectual disability, visual impairment and hearing impairment, house-mothers and healthcare providers. According to the Population and Housing Census conducted in 2010, these three categories formed part of the top four categories of disabilities recorded, with visual impairment persons constituting 40% of a total of 737,743 persons living with disabilities in Ghana. Proximity and easy access to the special schools selected, also informed my choice of these three regions. The students were selected from Catholic Special Vocational School in the Western Region,

Akropong School for the Blind in Akwapim Akropong, Eastern Region and Cape Coast School for the Deaf in Cape Coast, Central Region. These regions were selected because according to the Population and Housing Census conducted in 2010; these three regions formed part of the top five regions that recorded the highest number of persons living with disabilities in Ghana. This implies that if there is a Special School in any of these regions, there is the possibility to get the number of participants needed for the study.

The total population for the study was 54. A number of 29 students were selected from the three schools for the study. In Akropong School for the Blind I interviewed 13 students, 11 students from Cape Coast School for the Deaf and 5 students from Catholic Special Vocational School. The sample size from Catholic Special Vocational School was 5 students because these were the only mild category of intellectual disabled students who could give the information needed for the study. Again, 17 healthcare providers comprising 12 nurses and 5 medical doctors were purposively selected from Cape Coast Teaching Hospital and Effia Nkwanta Regional hospital respectively. Finally, 8 house-mothers were also selected from Catholic Special Vocational and Cape Coast School for the Deaf. My decision to choose these schools was because these schools are among the well-known special schools in Ghana, and also have the population/ category of students I deem fit for the work. Accessibility and proximity to these schools were also considered. Again, I chose these schools because the students were able to give me the needed information as far as the objectives and the research questions formulated to guide the study were concerned.



### Sampling Procedure

The purposive sampling procedure was used to select 54 respondents which comprised 29 students from the three selected schools for the study, 12 nurses from Cape Coast Teaching Hospital and Effia Nkwanta Regional Hospital respectively, 5 Medical doctors, and 8 house-mothers. Purposive sampling is the type of sampling in which the researcher uses his/her own judgment regarding the selection of participants from whom required information will be collected (Amin, 2005). The selection of the participants was purposively done to ensure that rich information about the access barriers to healthcare services that SWDs face in accessing health services in special schools was obtained and also to get a deeper understanding of the phenomenon.

**Table 1: Number of participants selected from the schools**

Name of Schools	Number of students	Male	Female
Akropong School For the Blind	13	7	6
Cape Coast School For the Deaf	11	5	6
Catholic Special Vocational Sch.	5	4	1
Total	29	16	13

Source: Field Data (2018)

**Table 2: Number of Health Care Providers Selected from the Hospitals**

Name of Hospital	Number of Doctors	Number of Nurses
Cape Coast Teaching Hospital	4	8
Effia Nkwanta Regional Hospital	1	4
Total	5	12

Source: Field Data (2018)

**Table 3: Total Number of House Mothers**

Name of School	Number of School Mother
Cape Coast School for the Deaf	5
Catholic Special Vocational School	3
Total	8

Source: Field Data (2018)

**Data Collection Instrument**

Polit and Hungler (1999) define data as information obtained during the course of an investigation or study. Data collection instruments refer to devices used to collect data such as questionnaires, tests, interview schedules and checklists (Seaman 1991). The main instrument for the study was an interview guide for the students. The interview guide was divided into five parts. Part one elicited information on accessibility of the physical structure of the health care facility to SWDs. Part two elicited information on attitudes of healthcare providers towards students with disabilities (SWDs). Part three elicited information on sources of finance/funding of SWDs for accessing healthcare. Finally, part four sought information on the available support services given to SWDs at the healthcare centres to facilitate access to healthcare services. Similarly, there was an interview guide for the house-mothers/caregivers. These are special individuals in the special schools who attend to the immediate healthcare needs of the students with disabilities. The interview guide for the house-mothers elicited information on how SWDs access healthcare services. The challenges that SWDs go through in order to access healthcare. Finally, there was an interview guide for the healthcare professionals (nurses and doctors). It also elicited information on their attitude

towards the students and the challenges they are confronted with when attending to SWDs.

### **Pretesting of the Instruments**

The process of developing and validating an instrument is in large part focused on reducing error in the data gathering process (Kimbertin & Winterstein, 2008). Validity and reliability are two significant aspects of all research (Brink, 1993). Careful attention to these can make the difference between good research and poor research, and can help to assure that fellow researchers and readers accept findings as credible and trustworthy (Brink, 1993). This is particularly vital in qualitative work, where the researcher's subjectivity can so readily cloud the interpretation of the data, and where research findings are often questioned or viewed with skepticism by the scientific community (Brink, 1993). Error is one of the integral elements in all investigations and is inversely related to validity and reliability. The greater the degree of error, the less accurate and truthful the results (Brink, 1993). It is therefore imperative to be watchful of the sources of error when conducting a research. Pretesting was done with the students of Aboom School for Special Needs, Cape Coast, and School for the Deaf, Fijai. Those who consented to participate in the study were then given a detailed description and purpose of the study by the interviewer. Each interview lasted between 15 and 18 minutes. In all, eight (8) students were interviewed from the two schools.

The interview guides were validated by expert consensual validation process. Brink (1993) opines that expert consensual validation from others knowledgeable in the research topic under study at various stages of the research process helps to improve the validity of the instrument. To this



regard, my supervisors reviewed the interview guide for the SWDs, housemothers and the healthcare providers. The supervisors' comments and suggestions were used to correct the mistakes in the interview guide to be sure that it measured what it intended to measure in the final results. For example, through this approach, research question 2 which initially sought to elicit information on knowledge of healthcare providers towards SWDs was amended to healthcare providers' attitude towards SWDs.

Data reliability is a state that exists when data is sufficiently complete and error free to be convincing for its purpose and context (Morgan & Waring, 2004). In addition to being reliable, data must also meet other tests for evidence. In this study, reliability was ascertained after the pretesting of the data collection instrument. After pretesting, all the corrections with regards to ambiguity and poorly constructed sentences in the data collection instruments were effected.

### **Validity and Reliability**

Validity and reliability are conceptualised as trustworthiness, rigor and quality in qualitative paradigm. According to Amedahe (2001), validity is the soundness of the interpretations given to the assessment scores that are validated, not the instrument. If the instrument measures what it intends to measure and the results are used for the intended purpose, then the instrument can be said to be valid. To achieve this, there is the need to eliminate bias and increase the researcher's truthfulness of a proposition about some social phenomenon by ensuring credibility, trustworthiness, transferability, dependability and conformability of the research study (Krefting, 1991). For credibility to be achieved there is the need to ensure reflexivity; which is a

rigorous self-scrutiny by the researcher throughout the research process. To achieve this I kept a journal throughout the whole research study to track my own ideas, responses and biases (Cohen, Manion, & Morrison, 2000). I did by ensuring that my responses were kept separate from the responses of the participants. I also employed member checking approach that is the data were sent to participants to correct any factual errors and also gave the participants opportunity to add further information and also check accuracy of the information (Cohen et al., 2000). I also employed peer briefing; that is I discussed the analysis process with my colleagues of which they gave the constructive criticism to ensure that the data analysis to a greater degree is accurate (Cohen et al., 2000). Dependability in qualitative study helps the researcher to provide detail description of research methods, peer examination processes place and the adoption of triangulation to further verify the data (Krefting, 1991). Again, dependability was achieved by carrying out member checks and providing a rich description of the research methods. Data was continuously coded and recoded in order to derive patterns that emerged from the research, and this also helped to analyse the coded data accurately.

### **Ethical Considerations**

According to Saunders, Lewis and Thornhill, (2012) research ethics relates to questions about how to formulate and clarify a research topic, design a research and gain access, collect data, process and store data, analyse data and write up research findings in a moral and responsible way. An ethical consideration in the field is inevitable when the work involves others, whether they are colleagues, respondents, assistants, or people in positions of authority (Perecman & Curran, 2006).

Ethical issues are highly relevant and require due considerations. According to Babbie and Mouton (2006), ethical standards require that researchers do not put participants in a situation where they might be at risk of harm as a result of their participation. The trustworthiness of a qualitative study is judged by whether the researcher conforms to standards for acceptable and competent practices and whether they meet standards for ethical conduct (Rossman & Rallis, 2003). It is as a result of this that necessitated my consideration for ethical approval for the study. Kara (2015) emphasized that it is important to ensure that the way in which the research is designed is methodologically sound and morally defensible to all those who are involved in it. To ensure this I first obtained clearance from the Institutional Review Board of the University of Cape Coast see (Appendix H). After this, I obtained permission from the school authorities to conduct the study.

In addition, permission was sought from the gatekeepers of the participants. Gatekeepers have a key role to ensuring that researchers gain access to intended participants and sites for research (McFadyen & Rankin, 2016). According to Sauders (2006), gatekeeper refers to the adult who controls or limits researcher's access to participants. For example, the top manager or senior executive in an organisation or the person within a group or community who makes the final decision as to whether to allow the researcher access to collect data from respondents or not. In view of this, permission was sought from the head teachers and teachers of the selected schools. Finally, the interviews were conducted after respondents had consented in writing and orally depending on the participants' ability to read and write. Participants who could not read and write were made to thumb-print the consent form after



all the necessary information regarding the study was provided in the local language.

Furthermore, the participants were assured of confidentiality and anonymity in the letters that were sent out to them (Sommers & Sommers, 2002). They were assured that their identities and comments would not be revealed without their approval. Additionally, the interview schedule excluded any identification details such as name and address of the participant. Other forms of identifiers were replaced with pseudonyms immediately after the interview data were recorded (Creswell, 2009; Sommers & Sommers, 2002).

#### **Data Collection Procedure**

The data collection was preceded by an introductory letter which was requested from the Head of Department of Education and Psychology, University of Cape Coast (see Appendix F). This was given to the special schools' authorities to seek permission and the appropriate days and time to conduct the interviews. Upon the receipt of the introductory letter by the participating schools and the appropriate time and days given, I went to the various schools to conduct the interview with the participants. All the interviews were held at the school premises of the respective schools selected for the study. Again, all interviews were carried out in selected classrooms at the respective Special Schools to avoid disturbances by fellow students. The intention was to maintain privacy and confidentiality of participants. Rights of participants to participate, decline or withdraw from the study were clearly explained to them. Interviews were conducted after participants had consented in writing or orally depending on the participant's ability to read and write. Participants who could not read and write were made to thumb-print the

consent form after all the necessary information regarding the study was provided in the local language. Each interview session lasted for an average of 30 minutes. Breakwell, Hammond, Fife-Schaw and Smith (2006) pointed out that spending an equal amount of interview time with interviewees ensures consistency which contributes to the trustworthiness of the study. In interviews, it is important for the researcher to record as much detail as possible (Deem, 2002). Therefore, to capture detailed sets of information during interviews, an audio recording device was used to enhance the accuracy of the data collected.

#### **Akropong School for the Blind**

Data collection was conducted between 20<sup>th</sup> and 21<sup>st</sup> March, 2018, after an introductory and clearance letters were accepted and minuted by the headmistress and the secretary of the academic board of the Akropong School for the Blind. All the students of the Rehabilitation class of the school were eligible to participate in the interview. They were purposively chosen because they were the class which consisted of students who were 18years and above. I briefed the students and their consent was sought. The participants were informed that they had the right to decline participation. One of the teachers then organised a session in the Library for the interview. I then called the students in turns. The students were told that the interview was being recorded for academic purposes of which they all agreed and consented to. I conducted the interview from 10am to 1:30 pm. By the close of day one, I had interviewed 9 students. I then played back the audio recorded interview and listened to ascertain any hitches. On the second day, I continued with the

interviews. At the end of day two, 4 more students were interviewed making it a total of 13 students.

### **Cape Coast School for the Deaf (CCSD)**

In CCSD, I was assisted by two teachers in the school who could sign and interpret the sign language for me to record. Again, introductory and ethical clearance was proof read and endorsed by the headmaster of the school. Students in Form 3 were eligible to participate in the study. The two teachers helped to translate the rationale for the study in sign language to the students. Their consent was sought and they were told that they had every right to decline to be part of the study; however, none of the students declined and were glad to participate in the study. A table and chair were set in one spare classroom in the school for the interview. One by one, each participant came in. Because of the communication barrier between the students and I, the two teachers had to assist me in translating the interview into sign language for the student. I asked the student a question, and then one of the two teachers seated around the same table signs for the student, then the student signs back for the other teacher to interpret orally to be recorded. By the close of day1, 7 students had been interviewed with the longest interview lasting 14 minutes and shortest 11 minutes. Day 2 saw the interview of the 4 additional students totalling 11 students. In CCSD, the 5 School-mothers were also interviewed. Each School-mother was interviewed separately in a spare classroom in the school.

### **Catholic Special Vocational School (CSVS)**

In CSVS, I had the intention to interview 10 students with mild intellectual disabilities, however, I could not meet the target. The class was



made up of students with mild and moderate intellectual disabilities. There were only 6 students who were classified as mild among the 14 students in that class. Students with mild intellectual disabilities can be educated and could therefore give coherent information pertaining to their healthcare to some extent and that is why I interviewed them. Even though they could respond to the questions some of them had difficulty with speech and therefore had to be assisted by a teacher to clearly express themselves for the recording purposes.

### **Nurses and Doctors of Cape Coast Teaching Hospital and Effia Nkwanta Regional Hospital**

The data collection was undertaken between 18<sup>th</sup> and 20<sup>th</sup> April 2018 in the Ward/OPD unit of the teaching hospital in Cape Coast metropolis. All consenting registered nurses in the OPD unit were eligible to be interviewed; trainee/student nurses were not eligible due to their inexperience. Nine (9) nurses and four (4) medical doctors were interviewed. In accordance with ethical regulations, ethical approval was obtained from the Research and Development unit of CCTH (see Appendix I). Nurses were then briefed about the study by the Head of Nurses of CCTH prior to the interview to make them aware of the research. Participation was voluntary and the head of Nurses did not have a role in recruiting nurses for the study. Individual nurses were approached on the Ward/OPD unit, and asked if they wished to participate, and if they agreed, they gave their written consent if they did not wish to participate of which two nurses declined. No nurse was forced to participate. The same procedure was applied at the Effia Nkwanta Regional Hospital after I was given an introductory letter from the Head of Administration (see

Appendix G). The introductory letter was sent to Ward A and C where I interviewed four nurses and one medical doctor.

### **Data Analysis Procedure**

Thematic analysis was used for the analysis of the data as it dealt with naturally occurring events and it provided vivid descriptions and information that led to answers (Miles & Huberman, 1994). Thematic analysis helped produce categories from the data, unlike quantitative strategies which predetermined categories. To this effect thematic approach to qualitative data analysis by Braun and Clarke, (2006) was adapted for the study. According to Braun and Clarke (2006), thematic analysis is a method for identifying, analysing, and reporting patterns within the data. Thematic analysis by Braun and Clarke (2006) has six phases which have been stated and described;

#### **1. *Familiarisation with the data***

In order to familiarise myself with the data, the audio recordings of the interviews were listened to several times (Gay, Mills & Airasian, 2009). Each interviewee was given a numeric code for easy referencing (Sommers & Sommers, 2002). The code assigned was based on the order in which the students were interviewed. The SWDs were given codes as (1-29). Healthcare providers were also give codes as (HCP 1-17) and finally, mothers were also given codes (1-8). Verbatim transcriptions of the audio interview were done, and hesitations and pauses were also noted (McLellan, Macqueen & Neidig, 2003). This was done to preserve originality and ensure that no information was misinterpreted or lost. One of the students, and all the eight mothers interviews were in the vernacular. These were translated and transcribed verbatim into English. The transcribed data was read through while listening

to the audio tape in order to ensure there were no omissions. Each interview was then summarised. This helped to conceptualise what the interviewees said and identify similarities and differences in their statements (Vanderpuye, 2013).

## 2. *Generating Initial Codes*

Coding is the process of examining the data for themes, ideas and categories and marking similar passages of text with a code label so that it can easily be retrieved at a later stage for further comparison and analysis (Taylor & Gibbs, 2010). Braun and Clarke (2006) also opine that coding process involves assigning words to phrases, quotations and chunks of the textual data and this helps to sort, reduce and distill the content of the interviews. Initial codes were produced through phrases used by participants during the interview. The codes facilitated my ability to locate pieces of data later in the process. A coding frame which contained codes and sub-codes was developed inductively from the interview transcripts. For example the following responses by participants were coded:

*I will say their (**attitude is awful**), because sometimes I do hear some of my friends who says the health care providers do shout on them, sometimes if they don't know they are visually impaired and they go there, they think they are coming to beg for funds or whatever and they begin to shout at them and so on (Student 1)*

*(**Very poor**), because they sometimes don't give the children all the drugs due them because of financial issues. At times too when we visit the health center they don't give us special treatment, the*



*treat us just the way they will treat anyone without disability*  
(School-mother 2).

Student 1's response to a question with regards to the attitude of healthcare providers towards SWDs, 'attitude is awful' was identified as a code in the responses. With the School-mother 2's response to her satisfaction with the healthcare services provided to SWDs in the hospitals, 'very poor' was marked as a code.

### **3. Searching for themes**

Braun and Clarke (2006), point out that searching for themes involves sorting the different codes into potential themes, and collating all the relevant coded extracts within the identified theme. Basically, this is the beginning of analyse of your codes and also considering how different codes may combine to form an overarching theme. Themes are phrases that identify what the data means. They describe an outcome of coding for analytic reflection. I developed a list of themes and begun to focus on broader patterns in the data, combining coded data with proposed themes (Braun & Clarke, 2006). For example the coded data from the response for research question 1 produced three themes. Thus, one theme was about the nature of the roads leading to the hospitals, accessibility to entry doors of the hospitals and finally, obstacles within the hospital facility.

### **4. Reviewing themes**

This stage involves checking if the themes work in relation to the coded extracts (phase 1) and the entire data set (phase 2), generating a thematic 'map' of the analysis (Braun & Clarke, 2006). I reviewed the major themes and sub-themes to ensure that the themes that could not be discussed

alone were collapsed and added to the one that was similar. Through this process the data was made clear and identifiable distinctions were made between themes.

### **5. Defining and naming themes**

This phase of the analysis is to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names of each theme (Braun & Clarke, 2006). I made sure that the names that were given to the subthemes were catchy and immediately give the reader a sense of what the theme is about. In all, 4 major themes and 10 subthemes were defined and refined by identifying the essence of what each theme is about and determining what aspect of the data each theme captures. An example of themes and sub-themes can be seen in Appendix D.

### **6. Producing the report**

According to Braun and Clarke (2006), writing the report is an integral part of the analytic process. At this stage, the researcher has to make sense of the raw data and present it in a way that it will be understood by others. In addition to this, it is important that the analysis give to some extent the concise, coherent logical, non-repetitive and interesting account of the story the data tell – within and across themes. I wrote the final report after I reviewed themes that made meaningful contributions to answering the research questions. To the best of my ability I wrote the report devoid of any personal sentiment and observer expectancy effect. I basically depended on the response that participants gave and I discussed the issues as they were.

In order to identify and refer to participants interviews, participants were given special labels.

For instance SWDs 1 was given the label **Student 1**, healthcare provider 1 was referred to as **HCP 1** and school-mothers were labeled **School-mother 1**.





## CHAPTER FOUR

### RESULTS AND DISCUSSION

#### Introduction

The chapter presents the results and discussion of the study. The study is to assess barriers that SWDs face in accessing health care services in selected special schools in Ghana. Data from the interviews were analysed in relation to the research questions and findings presented based on the following major themes;

1. SWDs accessibility to the physical structure at health facilities.
2. The attitudes of healthcare providers towards students with disabilities (SWDs)
3. Sources of finance of SWDs in relation to their access to healthcare services.
4. The available support services given to SWDs at the healthcare centres to facilitate access to healthcare services.

Prior to the presentation of the results in relation to the objectives and research question formulated to guide the study, it is important to take cognisance of the biographic information of the respondents who were involved in the study. A total of 29 students of which 13 students were selected from Akropong School for the Blind, 11 students were selected from Cape Coast School for the Deaf and 5 were selected from Catholic Special Vocational School participated in the study. Eight nurses from Cape Coast Teaching Hospital and 4 nurses from Effia Nkwanta Regional Hospital

respectively, 5 Medical doctors, 4 from Cape Coast Teaching Hospital and 1 from Effia Nkwanta Regional Hospital, and 8 School-mothers with 5 from Cape Coast School for the Deaf and 3 from Catholic Special Vocational School.

### **Biographic Information of the Respondents**

Analysis of the data collected shows that almost equal number (seven males and six females) of students were selected respectively from Akropong School for the Blind. For the Cape Coast School for the Deaf, the interview data demonstrates that five male students and six female students were selected. In Catholic Special Vocational School, 4 males and 2 females were selected. Paying attention to the ages of the students, it was found out from the interview data that in Cape Coast School for the Deaf, all students selected were all less than 26 years with four of the students between the ages of 18-20 years, and seven were between the ages of 21-25 years. Catholic Special Vocational School had two students who were between the ages of 18-20 years, three students were between the ages of 20-25 years, one was between the ages of 26-30 years and none of them was aged 31 years and above. Finally, in Akropong School for the Blind, four of the students were found between the ages of 18-20 years, one lied between the ages of 21-25 years, five of the student were between the ages of 26-30 years and three of the student were aged 31 years and above.

### **Analysis of Main Findings**

This section presents the findings of the key research questions guiding the study. The results have been presented in major themes and sub-themes emerging from the coded data.

**Research Question 1: How accessible are the physical structures of the health care facilities to SWDs?**

The first research question elicited information on accessibility to the physical structure of the health care facilities. This research question relates to description of how SWDs get to the hospital from their houses, accessibility of the route from the car parking or the bus stop to the hospital, difficulty in accessing the entry doors to the hospital, obstacles encountered on the walkways to the various departments in the hospital and the type of signals provided for the students with disability. Under this section, three themes emerged from the coded data collected from the students. These are:

- Nature of roads leading to the hospitals,
- Accessibility to entry doors of the hospitals and
- Obstacles within the hospitals facility.

**Nature of the roads leading to the hospitals:**

Many at times when persons living with disabilities are going to the hospitals or any place for transaction of any business of any kind, movement becomes an issue of which SWDs are not exception. In this study SWDs that is the visually impaired, hearing impaired and intellectually disabled movement to the hospital is the subject of interest. From the data collected from these category of students various views were expressed regarding how accessible or the nature of the roads leading to the hospitals.

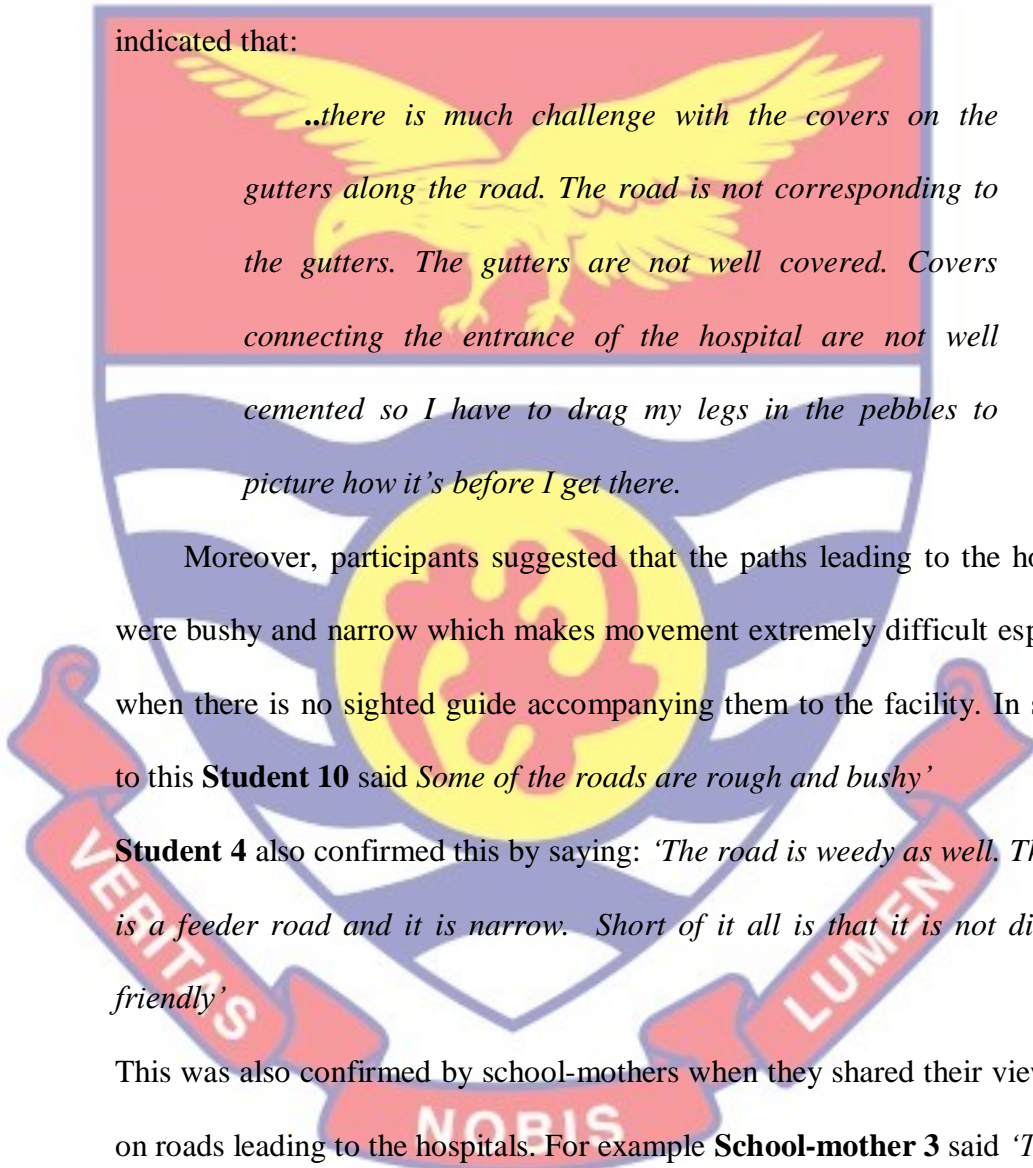
The majority of the student participants were of the view that the roads to the hospitals that they visited for healthcare were in bad conditions. In all 3 schools, concerns were raised regarding the untarred nature of the roads. For



example **Student 12** said: *is a bad road, because when we going, the car will be jerking.*

Some students complaint of open gutters along some of these roads leading to the hospitals which served as a trap to them especially the visually impaired in accessing health care services from the hospitals. **Student 13**

indicated that:



*..there is much challenge with the covers on the gutters along the road. The road is not corresponding to the gutters. The gutters are not well covered. Covers connecting the entrance of the hospital are not well cemented so I have to drag my legs in the pebbles to picture how it's before I get there.*

Moreover, participants suggested that the paths leading to the hospitals were bushy and narrow which makes movement extremely difficult especially when there is no sighted guide accompanying them to the facility. In support to this **Student 10** said *Some of the roads are rough and bushy'*

**Student 4** also confirmed this by saying: *'The road is weedy as well. The road is a feeder road and it is narrow. Short of it all is that it is not disability friendly'*

This was also confirmed by school-mothers when they shared their views on roads leading to the hospitals. For example **School-mother 3** said *'The road is not good. Most of the times I let someone help me put the child on my back and climb the hill with the child to the hospital'*

It is important to mention here that the visually impaired students complained more of the bad road as compared to the hearing impaired and intellectual

disabled. This could be as a result of their disability differences. Nevertheless, there were some hearing-impaired students who also said the roads leading to the hospitals were bad which impact negatively on their quest to access healthcare. On the contrary, a few of the participants suggested that the roads leading to the hospitals were tarred, cemented and very smooth to navigate.

Student 11 and 15 said: *For (Momo) Hospital, the road is not bad, some place is tarred, some place not tarred, as for the (Momo), the road is not bad (Student 11). The road leading to the hospital is tarred (Student 15)*

From the above quotation it is evident that students who did not complain of poor roads were those who probably might have utilised well-known and famous facilities. Given that (Momo) Teaching Hospital is a major health centre in City; one will generally expect that the road leading to the facility will be in good condition. This finding, however, echoes the inequality in the provision of infrastructure in favour of cities to the neglect of peri-urban and rural communities where roads leading to health facilities may not be in very good condition when compared to those in the highly urbanised centres in the country.

#### **Accessibility to entry doors of the hospitals**

Analysis of the data collected from the students revealed mixed views on accessibility to the entry doors at the facility/hospitals utilised by the SWDs. From the responses of participants, it was realised that the doors leading to the hospitals were either made up of fibre glass or wood. The doors had handles/holders that aided opening of the doors. The majority of the student participants said that the doors to the hospitals were easily accessible in that the doors are always opened to allow free

entry. The doors are broad and wide enough for easy access. **Student 6** made the following comment about accessible entry doors to the hospital *'the doors are opened, the ones that are closed have holder and I have to either push or pull before I enter'*

A student reported that some of the entry doors to the hospitals are not easily opened; the doors were made up of glass doors (sliding doors).

*The hospital doors are not opened. You push it yourself and enter; it's not wood doors. Its sliding doors; you push it and enter* (**Student 17**).

Another participant said sometimes he struggles to locate the door when he gets to the hospital because of his impairment. For example, a student 22 said to buttress his point:

*....but for the blind to access that place, you have to use your hand to locate where the door is, to know if it's opened or closed. So if it's opened you just access how big or wide the door is, then you go through* (**Student 22**).

This view on ease of access to the hospital doors and entry path shared by the students was echoed by the majority of the school mothers interviewed. The school-mothers view confirmed the fact that entry doors to the hospitals are always opened to allow easy access. There are no obstacles within the hospitals; it is only the room that is mostly closed that you have to push. **School-mother 3** said: *'From where we alight to the health facility is easily accessible there are no gutters or whatsoever; the doors are always opened'*



**School-mother 5** also said: *'When the car alights us, we walk to the facility, since the road is not bad'*.

This view is consistent with the healthcare providers' views regarding to accessibility to the hospitals. The majority of the healthcare providers said the hospital buildings were not disability friendly or it is not accessible to SWDs given reason to that effect. A healthcare provider at (Wawa) Hospital mentioned that movement within the hospital was a challenge to SWDs, especially the visual impaired and the physical challenge. For example **HCP 1** made a very important comment to that effect as captured below:

*For me honestly, I think the hospital was purposely made not disability friendly. When you go to the access ways to the Wards it has stairs that ideally, it shouldn't have been there. The wash room has no rails to aid or support the SWDs who visit the hospital*

It is evident from the different views shared by the participants on the entry doors to the hospital that mostly the doors are opened to allow free and easy access to the hospitals.

### **Obstacles within the hospitals facility**

Participants were required to talk about the obstacles that they encounter within the hospital building that obstruct their movement to the various departments within the hospitals. On this theme, the majority of the students interviewed said there were a lot of obstacles in the hospital buildings that make SWDs very difficult in accessing healthcare services. Some of the participants said there were a lot of staircase in the hospital building that make climbing to the consulting rooms and other departments within the hospital difficult. For example **Student 2** had this

to say: *'... for instance, like accessing the OPD, I have to climb some stairs, and climbing the stairs is a bit difficult. If you are not careful and the ground is slippery you can easily fall'*.

Still with the issue of obstacles within the hospital, students 14 and 24 respectively narrated how the arrangement of tables and chairs in the

hospitals obstructs their movement. Excerpts of their comments are: *'The position of the chairs and tables that are set to inspect peoples NHIS and folders make it more difficult when going through the hospitals'*.

**(Student 14)**

*'The chairs at the OPD hinder our movement especially if you are not familiar with the arrangement'*. **(Student 24)**

Other patients and visitors to the hospitals served as hindrance to SWDs who visited the hospitals. This was basically in reference to the visually impaired.

*One of them is that there are a lot of people in the hospital so some people will be standing in your way not knowing that you are blind and they expect you to see them and swerve them, which I do bump into them. And on the way to the laboratory at the (Mampam) Government Hospital, there are some glasses, going through is difficult at times* **(Student 16)**.

The views of the students affirm what some of the healthcare providers mentioned. It became evident from the interviews with healthcare providers that consulting rooms are on storey buildings making it difficult for SWDs

because of the stairs leading to these consulting rooms’... *Like the staircase I talked about. Those who use the wheelchairs will find it difficult to navigate themselves to the consulting room*’ (HCP 2)

At some of the hospitals there are stairs to climb before getting to some of the consulting rooms. For example HCP 3 mentioned that: *‘The structure is not really disability friendly even though there is a lift but sometimes it breaks down and you need to climb at least 26 steps before you can get to some of the departments in the hospital’.*

There are no tactiles or brailles for the visually impaired in the hospital to aid them easily access their healthcare services. This was confirmed by a healthcare provider in (Waawa) hospital when he said. *‘There is not any tactile for visually impaired. Those that are in the hospital are not meant for the disabled’.* (HCP 1)

There are no directional signs and those that are available are not disability friendly especially to the visually impaired. Again, a participant indicated that he has to always visit a nearby bush whenever he visits the facility. The reason for this is captured in the following verbatim excerpt *and their wash rooms are not in a good shape, in that I have to go to a nearby bush to ease myself anytime I visit the hospital* (Student 9). The excerpts of SWDs and healthcare providers were not in contradiction. They clearly gave the true picture of most of public buildings including hospital facilities in the country which is mostly not disability friendly.



## Research Question 2: What are the attitudes of healthcare providers towards students with disabilities?

This research question sought to examine the attitudes of healthcare providers towards students with disabilities. This research question relates to description of healthcare professionals (nurses and doctors) attitudes towards students with disabilities at the hospital. Under this section, two themes emerged from the coded data collected from the students.

Good attitudes

Bad attitudes

### Good Attitudes

The majority of the participants said the attitudes of healthcare providers were good. Some of the participants said the healthcare providers behaved well towards them. **Student 16** pointed out that: *'They always behave well towards me; they have good character and have enough time to listen to my problem'*.

Some said the healthcare providers were friendly and welcoming. Students 17 and 26 confirmed this when they said: *'They are very friendly, and when you go there they welcome you nicely.'* (**Student 17**) *'They are very cordial, they are friendly'* (**Student 26**).

They listened to their plight whenever they visited the hospital. There was an instance where a participant said a nurse had to clean a mess SWDs had done to himself when he had come to seek healthcare. In the words of **Student 25** *'...someone once messed his pants and the nurses clean it for him'*. This was also confirmed by a healthcare provider, *... I treat them as any other person knowing their conditions; any necessary help that I can offer them I do it.* (**HCP 12**).

Healthcare providers were said to be calm and accommodating. Specific reference was made to medical doctors to be accommodating as compared to the nurses.

*...some are accommodating while others are hostile. For the doctors in particular, they are accommodating. The ones that I have visited, they, the doctors per say are accommodating, but the nurses sometimes, not all of them though, a few of them are a bit rude in their approach towards you (Student 2)*

According to the HCPs who were interviewed, they are not rude to people with disabilities rather they treat them well. In confirmation of this **HCP 2** said:

*'I don't think we are rude to them, normally when we see the person has disability it touches you to help them. We treat them well. Even the Prisoners when they come, priority is given the' (HCP 2)*

Communication which is said to be key in healthcare delivery between patients and healthcare providers was said to be cordial between SWDs and healthcare providers as outlined by a participant. The majority of the students said they have never experienced any verbal abuse from any healthcare provider.

*...Never, just that sometimes when they are attending to you and it is painful and you can't sit down they shout at you thinking it is not painful (Student 11)*

Upon critical look at the responses from the three categories of students that were interviewed that is the hearing impaired, visually impaired and intellectually disabled, students with hearing impairment mostly said the attitudes of healthcare providers are good as compared to the responses from the students who are visually impairment and intellectually disabled.

### **Bad Attitudes**

Not all the participants agreed to those who said the attitudes of the healthcare providers were good. Some had a contrary view. Some participants said the healthcare providers had bad attitudes towards SWDs.

*At the OPD, they are very rude. Let me say they are very rude.*

*That is at the (Waooo) Hospital. At OPD the nurses there are very rude but in the Eye Clinic itself, the nurses are calm (Student 9)*

School-mothers were not left out with regards to their assertion on the attitudes of healthcare providers towards SWDs. School-mother of (Kenken) School complained of lackadaisical attitude on the part of the nurses whenever a student is sent to the hospital for healthcare services. **School-mother 1** said: *they don't even mind you. But for the private hospitals, the way they will receive you, makes you feel happy.*

Participants shared the view that because of their impairment healthcare providers disregarded them and showed bad attitudes towards them. Insults were sometimes meted out to participants by some healthcare providers often without any recourse. Some healthcare providers even used unsavoury words like "foolish" on SWDs. There were instances when some healthcare providers will shout at the SWDs in the hospitals. Participants narrated how



some healthcare providers were gossiping about them. Excerpts of their comments are: *Some of the nurses at (Obroboi) District Hospital for instance gossiped when I visited there during my pregnancy, saying how could a blind person be pregnant. (Student 7)*

*Sometimes when you call them, they snob you, they do say you should get away, and that you like disturbing too much. I was once a victim at the (Yooo) hospital (Student 9)*

*Some have a negative perception about those with disability, they think we don't belong there, and also they delay us. They will just ignore you at times (Student 5)*

A participant said the healthcare providers lacked expertise and were not committed in attending to SWDs as compared to other hospitals he has visited abroad. A student had this to say:

*I will say of some them their attitude towards the SWDs is not good. For instant if you complain you have a headache and a nurse will tell you she will be with you shortly and that might be the end. This is not seen in other parts of the world, like South Africa per say where I visited. They are ever willing to help. (Student 8)*

Attitude of healthcare providers towards SWDs were reported differently from the point of view of the students. Eventhough bad attitudes were narrated by some students, nevertheless, students who reported good attitudes of healthcare providers out numbered those who reported bad attitudes. On the contrary, none of the seventeen healthcare providers interviewed said anything bad to their attitudes towards SWDs.

**Research Question 3: What are the sources of finance/funding of SWDs for accessing healthcare?**

Financing health care services in Ghana is very crucial and a challenge for many especially those living with disability. In this regard, I explored how SWD finance their healthcare bills that accrued from the services received from the hospitals. To answer this research question, I explored how transportation cost to the hospital and, the hospital bills were paid. How SWDs were registered under NHIS, challenges faced by SWDs in the use of NHIS and the general satisfaction of healthcare services in Ghana. Three main themes emerged from the data collected. They are:

Paying the healthcare services bills

Challenges with the use of NHIS

General satisfaction of healthcare services in Ghana.

**Paying the healthcare services bills**

This revealed how the participants manage to pay their hospital bills. The majority of the participants said it is family members who pay their bills, that is, fathers, mothers, siblings, uncles, aunties and other relatives. Some comments in support of these are

*My family especially my sisters pay my healthcare bills (Student 6).*

*...my Brother and Mother, and sometimes my Uncle help in paying the cost that are incurred at the hospital (Student 10)*

Others also said they pay for their own hospital bills from monies they have saved personally. A participant said sometimes he goes out to preach the word of God and the proceeds accrued is given to the mother and is used to pay his healthcare service bills when the need arises.

*Most times I give my mother the money. I get the money from preaching the word of God. I am a preacher. So the offerings I get sometimes 30 Ghana cedis or 40 Ghana cedis I give that money to her, I give her money for everything we do. I give her money for everything. We are three in number, one girl and two boys, people like me.*

**(Student 25)**

Others had sponsorships from cooperate entities and individuals. One participant said a White lady pays his healthcare bills for him. **Student 24** said:

*'One White Lady who likes me and took me as a friend pays my healthcare services bills.'*

Another participant said it's the District Chief Executive in his District who pays for the renewal of his NHIS. *'The District Chief Executive renews my NHIS card'* (**Student 15**).

A participant said he was a SSNIT contributor so deductions are made from his SSNIT contributions to pay for his healthcare services bills.

**Student 2** confirmed this with this verbatim statement: *'In my case, because I was a SSNIT contributor they deduct it from source'*

Some participant also relied on NHIS but sometimes it does not cover all the bills. **Student 6** *'I use the NHIS card so the card takes care of the bills but sometimes the card doesn't cover all the bills'* (**Student 6**)

School-mothers who were interviewed confirmed some of things said by the SWDs with regards to payment of healthcare services bills. Some even said



sometimes they pay for the students. A school-mother said it is the school that pays upfront the healthcare services bills for the student. Excerpts from school-mothers 4 and 6 are reported respectively as *'It is the school authority that gives the money to take the children to the hospital'* (**School-mother 4**). *'Sometimes I use my own money to pay when let say the school has closed.so*

*later I send the receipt for refund'* (**School-mother 6**)

The school-mothers' statement show that the various special schools use their insufficient government subvention to also pay for the healthcare services bills of SWDs. This could put pressure on the schools' coffers which in limit the certain provisions the school could provide.

A healthcare provider confirmed this inability of some SWDs to pay the healthcare bills. **HCP 1** said: *'...some of the SWDs are not able to foot their bills. Some of them have to beg other patients to foot their bills and sometimes we the nurses have to dip our hands into our pocket'*.

It was so obvious from the responses above that payment of healthcare bills of SWDs was a challenge. Mostly families of these SWDs had to pay these bills.

#### **Challenges with the use of NHIS card**

The majority of the participants had registered with NHIS but had challenges with it use. A participant said the process of acquiring the NHIS card is tedious. He had to join queue for hours before he acquired it. *'Acquiring the card is tedious, because the process is long. With long queues, where they end up telling you they have a quota they will attend to, leaving the rest'* (**Student 5**).

Some participants also said the NHIS card did not cover most of the drugs prescribed for them. *'Sometimes you go there and they will tell you the*

*drug they are given you isn't covered by the NHIS so you have to go and buy it elsewhere' (Student 12).*

A participant said at (Hweehwee) hospitals he was told the NHIS card could not cater for the cost of service. Again, other participants were of the view that you don't get the best drugs with the use of the NHIS card. *The challenge is that you do not get the best drugs, those you get are just some cheap drugs. You even have to buy some in addition (Student 14).*

Some also said they had to pay between 25 Ghana cedis and 45 Ghana cedis for the renewal of the cards.

With the use of the NHIS card you are given less expensive drug which is not good as suggested by **Student 4** *'There are a lot of challenges, because holding the NHIS card, they provide you with drugs of less cost and ask you to go buy those that are expenses'*

The challenges encountered by SWDs in the use of NHIS card was confirmed by a school-mother who said the drug that they buy for SWDs, specifically, intellectually disabled is expensive and that the card is unable to cover the drugs.

*Sometimes the medicine to be given is expensive and because you are using the NHIS card they will say that kind of medicine is not available but the truth is some will be there. So sometimes when I go I tell them madam please if there is some available I am buying it because I am a school-mother and I can't go and join queue in a*

*different Drug-store where I would not get*

**(School-mother 3)**

The introduction of NHIS into our healthcare system came with its challenges and of course, these challenges are not a preserve of those who do not live with any form of disabilities but also those who live with disabilities of which SWDs are inclusive. SWDs ideally should have been exempted from all forms of payment with regards to their healthcare service but that has not been the case in the country which makes it very difficult for SWDs in accessing healthcare services.

#### **General satisfaction of healthcare services**

When SWDs were asked to express their views on how satisfied they are with healthcare services, quite a reasonable number of them said they were satisfied with the service delivery. However, they were dissatisfied with the services rendered to them. Some of the participants who were satisfied with the service outlined varying reasons which included; *'in my district asthmatic patients do not pay for the drug due to that I am satisfied'* (**Student 14**). A participant said *'the Nurses and Doctor treat us equally as other patients'* (**Student 17**). Some students said nurses and doctors are humble and respectful, they do not shout at them. On the other hand some participants registered their dissatisfaction about the healthcare services delivery. A participant said the healthcare service is very poor; stating that *'the attitude of healthcare providers was not good; drugs given were not effective and not up to standard'* (**Student 21**). A student again, said it's difficult getting funds to buy drugs. Furthermore, **Student 6** said that *'at the dispensary unit to be corrupt; they hide the drugs. The Doctors and Pharmacists have their own*



*drug stores behind the hospitals where they sell some drugs’ A visually impaired student said they have difficulty in accessing the hospital building.*

The following are what some students said:

*As for me I am satisfied; I quite remember somewhere in Senior High School, when I started experiencing this eye problem, the Doctor whom I visited did so many test and tried giving me a lens but could not get one at his facility and went all the way to give me some money to get the lens from Koforidua hospital*  
**(Student 19).**

*Generally, from the doctors’ perspective, I think some of them treat us well, because they will tell you what is wrong with you describing everything for you to know and give you prescription. But then I have issues with the NHIS which doesn’t cover all our expenses when we visit the hospital* **(Student 20).**

It was evident from the responses that even though there were issue with access to healthcare services, SWDs to a larger extent were satisfied with the care received. The school-mothers had a contrary view to that of the SWDs. The school-mothers were not satisfied with the service meted out to the students. For example **School-mothers 1 and 2** had this to say: *‘Very bad, for me, giving them medicine should have been*

*free. They government has to consider those with disability (School-mother1).*

*Very poor because they sometimes do not give the child all the drugs due them, because of financial issues. At times too when we visit the health center they do not give us special treatment, they treat us just the way they will treat anyone without disability (School-mother 2)*

Healthcare providers were not left out they also had this to say with regards to their general satisfaction of healthcare services rendered to SWDs.

**HCP 7** said:

*I will say it is good because the hospital has a priority system. We fish them out and prioritize them. We have the protocol for them. If I identify that you are visually impaired, I will treat you with much care. You may find a Policeman or King in the queue, and we give them that priority them*

**HCP 1** said:

*As it stands now I wouldn't say it's very good, it's something that needs improvement though we are doing our best but there is more room for improvement. The system and its surrounding is not favouring SWDs. For instance an X-ray situated in an office where every patient would*

*have to go for the service needed, but it could be wheeled to the disabled rather than they coming to it, it would have been better. I will say we are doing our best but we are not at where are supposed to be.*

**Research Question 4: What support services are given to SWDs at the healthcare centres to facilitate access to healthcare services?**

This research question sought to explore available support services at the hospital for SWDs. This relates to the description of what special support services are given to SWDs at the hospital, Sign Language interpreters' availability at the hospitals and how useful they would have been to SWDs if they were available at the hospitals, and assistance SWDs get at OPD unit in processing their medical cards. Availability of wheelchairs, clutches, rails, magnifying lenses, etc within the hospital to aid SWDs who visit the hospital. Participants' responses to this question are categorised into two themes. These are;

Sign Language interpreters and their usefulness

Support services provided by hospitals to SWDs

**Sign Language interpreters and their usefulness**

Sign language is very crucial in the daily communication of SWDs especially the hearing impaired. To this end SWDs were interviewed to know how they communicate with healthcare providers at the hospitals when they go to seek healthcare services. From the responses, the majority said they have never had an encounter with any sign language interpreter in any of the hospitals visited. In support of this



**Student 14** said *'I have not come across any sign language interpreter. Last I heard on news it that they must train doctors to understand sign language'*.

When asked how useful these sign language interpreters would be if they were available, participants outlined varying importance which included; *'their presence would have aided the communication between the healthcare providers and me (Student 18)*. Another student said;

*No; I wish they were there, because I could have communicated very well since they understand my language and also, I understand theirs. Their absence has caused me a lot, because at times I have to write, which at times I cannot spell the words (Student 19).*

Sign language interpreters' absence in the hospitals created communication gap and also affected healthcare delivery as mentioned by the participants. Doctors in particular could not interpret sign language and had to imagine and write something on his behalf. Another participant said the absence of sign language interpreters had forced her to write what kinds of sickness she was suffering from at the hospital of which her handwriting was not eligible for the healthcare providers.

**Student 23** had this to say: *'No interpreters, due to that I have to write and other times I have to go with my parents. Sometimes my writing is not clear to the doctors, and I observed that the doctors are just guessing'*

Even though there were, lack of sign language interpreters in the hospitals specific mention was made to only two hospitals that had Sign language interpreters according to the students interviewed.

Healthcare providers also expressed their opinion on how useful sign language interpreters in the hospitals would have been. All the 17

healthcare providers could not sign or interpret sign language. Excerpts from healthcare providers are reported verbatim below; *'No, I don't sign. When I was in school it wasn't taught by then'* (HCP 8)

*Sign language interpretation is very important, you know we are taking care of a lot of people including those who are deaf and dumb so it will help. Else you can give different diagnosis* (HCP 6)

Again, a healthcare provider said it affects how they perceive the students' illness to be. HCP 7 said: *...it affects healthcare delivery a lot because you would not even know the grievances of the disabled person'*

It was evident from the healthcare providers that their inability to sign and also interpret sign language affected the healthcare service rendered to SWDs in one way or the other.

However, the School-mothers were able to sign and also interpret sign language. School-mother 4 said: *Yes, I am able to sign and I can also interpret sign language. But it would have been helpful if there were interpreters in our various hospitals.*

SWDs, especially, the hearing impaired and school-mother could sign and also interpret sign language, however, the healthcare providers were deficient in the sign language and its interpretation which has a

serious consequence on the delivery of healthcare services of SWDs especially the hearing impaired.

### **Support services provided by hospitals to SWDs**

SWDs ideally should have some special support or help within the hospitals. With regards to special support services, I sought to explore if there are wheelchairs, clutches, audio aids, lenses among others to assist SWDs in the hospitals. Responses from the students revealed that some hospitals had wheelchairs to convey SWDs within the hospital when the need arises. For example **Student 11** said: *‘As for wheelchairs yes they have it; but for the others, like sign language interpreters I have never seen any’*

The visually impaired are given lenses to aid their movement in the hospital as mentioned by a participant. Reference was made to one hospital to be the only clinic with well-trained specialised personnel and had all machines. *‘...in that hospital they told me there are some equipment that they use in helping the low vision people such as lens’* (**Student 7**).

Some participants also said there were white canes, clutches, stretches to aid SWDs movements within the hospital. A healthcare provider admitted that they had *‘priority system’* put in place for SWDs who visit the hospital. *‘we have the Priority System of which I serve as the Priority nurses who minds the priority window. My work is to identify them that have disability’* (**HCP 2**).

A participant said there was sponsorship for the visually impaired in a hospital he visited for healthcare services. A healthcare provider confirmed that there was Social Welfare Service in the hospital where those who are unable to pay their healthcare bills are assessed and given the support they require. For



example **HCP 1** said: *'We have the Social Welfare Department in the hospital. They screen persons who put themselves up not to be able to pay their bills'*. However, there were a few number of participants who said there were no special support for SWDs at the hospitals visited. Some said they had to join the queue for 2 to 3 hours before their cards are processed at the OPD.

*'...you have to join a queue, and they don't even consider the fact that you are impaired. There was an instant where I had to stand for about two hours, because the seats were full'* (**Student 3**).

A student who is visually impaired said he had to familiarise himself with the hospital environment in order to go through the process of getting his card.

**Student 7** said: *'I have familiarise myself with the environment, so I take of those errands by myself by getting my card processed at the OPD unit. No special support for me'*

A school-mother said sometimes when she goes to the hospital and the student happens to be hyperactive, she has to put the student at her back whilst trying to get his/her card been processed without any external help. She does that because the hyperactive student could cause damage to things within the hospital.

*...I put the child on my back and quickly rush to the OPD and get the card for the children. At the OPD unit, the nurses don't help at all. Unless it is an emergency situation, but if you go and tell them that O' Nurse this is a special child, none*

*will help you process the card or even give you preferential treatment (School-mother 3)*

It can be deduced from the above that eventhough there were some support services at the various healthcare centres, nevertheless, there were a lot more challenges. This implies that a lot more has to be done in the area of support services in our hospitals.

### **Discussions of Findings**

#### **Accessibility of the physical structures of the healthcare facilities to SWDs.**

Overall the narrative or findings on accessibility of physical structures of the healthcare facilities as per the views of SWDs, healthcare providers and school-mothers demonstrate that physical structures of the various hospitals that are utilised by SWDs are largely problematic. Several barriers including structural obstacles, inaccessible medical equipment, toilet facilities, and doorways, were identified as factors that hindered access of health care services. The thematic analysis of data gathered indicated that healthcare structures were not accessible by persons living with disabilities. It was revealed that staircase, doors, toilet seats, rails and signage, within the hospital building were not disability friendly making it extremely difficult for SWDs to access it. The finding on accessibility to health facilities is in agreement with the revelations reported by researchers such as Singer et al. (2017), Badu et al. (2016), Afio et al. (2016) and Badu, (2014). Section 6 of Ghana' s Disability Act 715, 2006 and Article 9 of the United Nations Convention on the Right of Persons with Disability require that buildings, roads, indoor and outdoor facilities including school buildings, medical facilities and work places are

made accessible to persons with disability. However, the findings of this study together with that of Singer *et al* and Afio *et al* on accessibility to healthcare facilities by persons living with disabilities are in contravention of what Section 6 of Ghana's Disability Act 715 and Article 9 of the United Nations Convention on the Right of Persons with Disability require. The contradiction in this finding with the Disability Act and UNCPD could be attributed to lack of political will to enforce the accessibility laws that seek the welfare of persons living with disability. Despite the efforts of the government to establish a conducive environment for persons with disabilities in all spheres of life there is still difficulties in terms of accessing physical infrastructure as most buildings including hospital facilities in Ghana and elsewhere in other developing economies do not have facilities such as ramps, lifts that could aid disable persons when they visit hospitals. Some of the existing accessibility facilities are not designed according to the required standards and as a result persons with disabilities continue to face difficulties in accessing them. The implications of these are discrimination and violation of the rights of persons with disability in accessing healthcare services which is a basic right of all persons, and deliberately putting impediments to the disabled to exhibit their full potential and contribute to the development of Ghana.

#### **Attitude of healthcare providers towards students with disabilities.**

Attitudes of healthcare providers towards patients in the hospitals were reported differently by clients who access healthcare services. The findings from the views of participants that is the SWDs, healthcare providers and school-mothers on the attitudes of healthcare providers towards SWDs do not stand alone. The works of scholars such as Sctchidanand *et al.* (2016), De



Benedictis, (2014) and Kathleen and Fatata-Hall (2013) confirm the finding of this study. Their findings showed that there was a favourable attitude of healthcare providers towards SWDs. In this study, the findings for the research question on the healthcare providers attitude towards SWDs also showed that the attitudes of healthcare providers towards SWDs was generally good as reported by the participants including SWDs, Nurses and Doctors, and School-mothers. SWDs who were interviewed said healthcare providers showed much concern towards their healthcare needs; they are calm and accommodating, friendly and welcoming. The reasons outlined by the SWDs interviewed were not much different from the School-mothers interviewed and that of the healthcare providers who were interviewed. However, the finding of Khan et al. (2016) contradicts the findings of this study and some other studies in relation to attitude of healthcare providers towards SWDs. Khan et al's findings showed a more negative attitude towards persons living with disabilities which includes SWDs by healthcare providers. This could be as a result of difference in research methods employed. Khan et al used quantitative study employing mean and standard deviation in analysing the data based on statistical modelling to make conclusion on their findings. But in the works of Sctchidanand et al. (2016), De Benedictis, (2014) and Kathleen and Fatata-Hall, (2013), they employed qualitative methods dwelling on qualitative data analysis procedure to ascertain the findings. Interviews were used as a means of data collection which could possibly explain why the researchers got indepth revelations on the issue of the healthcare providers' attitudes towards SWDs to conclude on good attitude portrayed by healthcare providers as compared to the questionnaire employed by Khan et al, (2016) in

their study which found negative attitude of healthcare providers towards SWDs. This is because interviews allow the researcher to get detail information, and also allows the researcher to ask questions at several levels to get the most information from the subject as compared to questionnaire (Burcu, 2000).

### **Funding healthcare services bills of SWDs**

The finding from this research question showed that healthcare services bills of SWDs is funded by their various Schools, SWDs, Parents and other individuals. The finding again showed that the majority of the participants subscribed to NHIS but had a lot of challenges in using the NHIS card. This was in agreement with WHO, (2016) report which indicated affordability of healthcare services and transportation as two main reasons why persons with disabilities do not receive needed healthcare in low –income countries. Badu et al. (2015) showed that the majority of the participants in this study used NHIS as a regular source of payment for healthcare and also indicated that NHIS did not cover all their expenses and equipment. Again, this finding supports the theory underpinning this study that is Health Service Utilization Model by Andersen, (2008). In this theory Andersen outlines three main tenets to be factors that propel an individual to access healthcare services. One of such tenets is the enabling factors which talks about financial factors considered to be a key factor in enabling an individual to access health care services. The theory establishes that individual financial factors comprises the wealth and income at the disposal of that individual which enables him/her to pay for the utilisation of the health services and the effective price of health care which is determined by cost-sharing

requirements and the individual's health insurance status (Andersen, 2008). This supports the finding of this study because SWDs ability to fund their healthcare bills is contingent on themselves and other individuals. Some SWDs had to do some jobs in order to pay their healthcare bills.

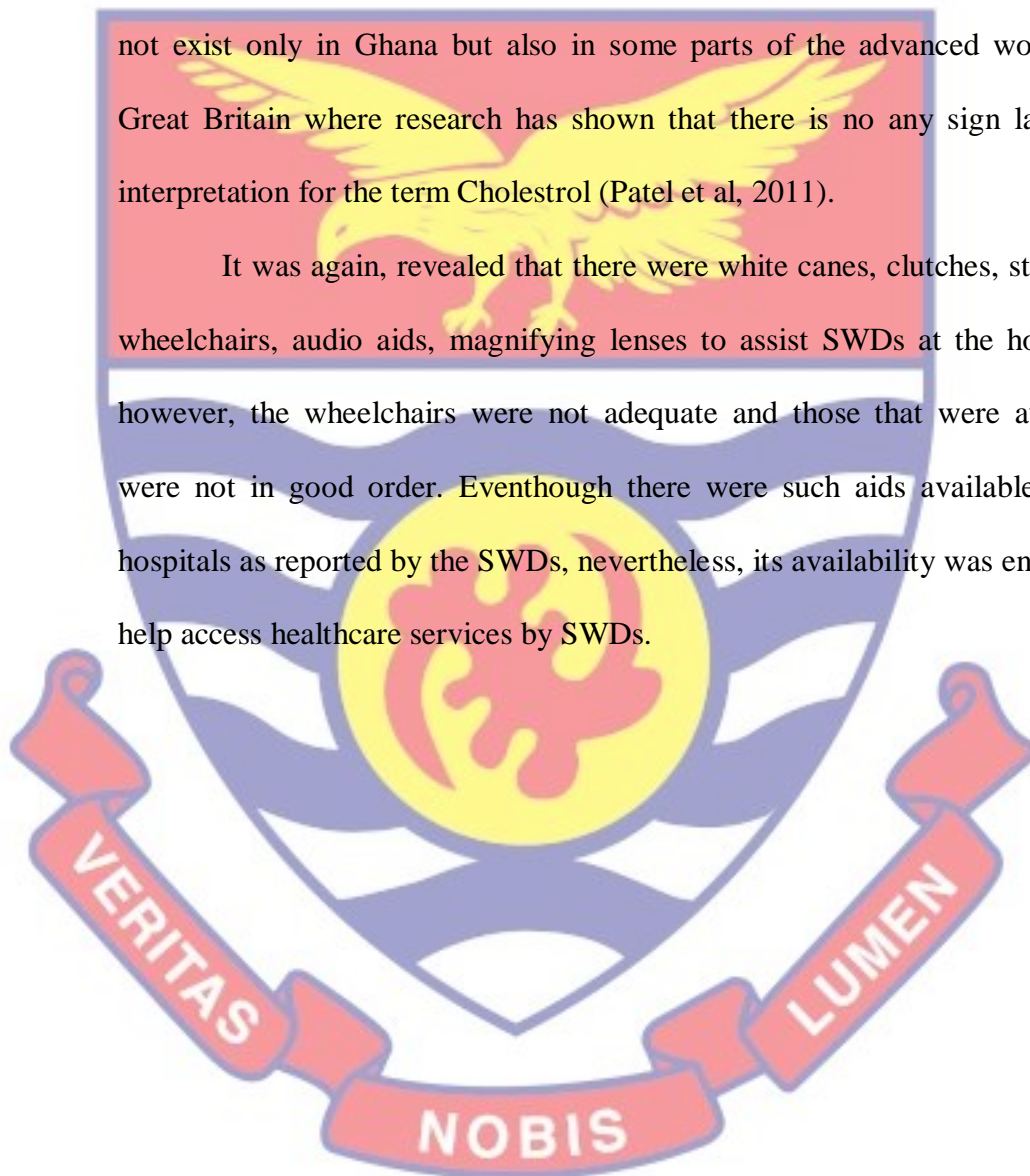
#### **Available support services given to SWDs at the hospitals**

Findings for this research question showed that there was lack of Sign Language Interpreters in the various hospitals visited by SWDs and that their absence causes a lot of problems such as wrong prescription of drugs/medication, which could lead to the loss of life of the patient in an event that could result in tarnishing the image of hospital and also putting the healthcare providers profession in jeopardy. This revelation is confirmed by the works of Khan, Umar, Naeem and Marryam (2016) when they revealed that communication barrier between the healthcare providers and PWDs often made the PWDs to be subjected to the opinions and judgements of service providers in order to gain access to needed healthcare services. Additionally, Drainoni et al (2006) revealed that the absence of specialists such as sign language interpreters in most healthcare centres pose a challenge to the hearing impaired when accessing healthcare confirms these findings. In medical practice, it's said that language deprivation and associated language dysfluency can contribute to serious misunderstanding as revealed by Alex et al (2016) which is in line with this finding. The finding could be attributed to the healthcare care needs of SWDs, especially the hearing impaired. This is because hearing impairment did not start yesterday and it has been with us since time in memorial and therefore something should have been done long ago to help bridge the communication gap. When I interviewed a medical



doctor with regards to sign language interpretations and its effects on the healthcare needs of the hearing impaired, he said they are trained to take care of the majority in the society. This clearly shows the disparity and disregards that society and for that matter the Ghanaian Education has been skewed in favour of people living without disabilities. This is because the problem does not exist only in Ghana but also in some parts of the advanced world like Great Britain where research has shown that there is no any sign language interpretation for the term Cholestrol (Patel et al, 2011).

It was again, revealed that there were white canes, clutches, stretches, wheelchairs, audio aids, magnifying lenses to assist SWDs at the hospitals, however, the wheelchairs were not adequate and those that were available were not in good order. Eventhough there were such aids available in the hospitals as reported by the SWDs, nevertheless, its availability was enough to help access healthcare services by SWDs.



## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### Introduction

This chapter presents a summary of the research process as well as the key findings that emerged from the research. The chapter also contains the conclusions and recommendations that were made based on the findings of the study. Areas suggested for further research are also presented in this final chapter of the study.

#### Summary

The focus of the study was to assess barriers that SWDs face in accessing health care services in selected special schools in Ghana. It sought to examine SWDs accessibility to the physical structure at health facilities, examine the attitudes of healthcare providers towards students with disabilities (SWDs), determine sources of finance of SWDs in relation to their access to healthcare services and investigate the available support services given to SWDs at the healthcare centres to facilitate access to healthcare services.

The research was a qualitative study which was based on phenomenology. The population of the study was SWDs, School-mothers and Healthcare providers. These were students with intellectual disability, visual impairment and hearing impairment. The purposive sampling procedure was used to select 54 participants which comprised 29 students from the three selected schools, 17 healthcare providers (nurses and doctors) from Cape Coast Teaching Hospital and Effia Nkwanta Regional Hospital respectively,

and 8 School-mothers for the study.

The main instrument for the study was an interview guide for the students. The interview guide was divided into five parts. Part one elicited information on accessibility of the physical structure of the health care facility to SWDs. Part two elicited information on attitudes of healthcare providers towards students with disabilities (SWDs). Part three elicited information on sources of finance/funding of SWDs for accessing healthcare. Finally, part four sought information on the available support services given to SWDs at the healthcare centres to facilitate access to healthcare services. Similarly, there was an interview guide for the School-mothers. These are special individuals in the special schools who attend to the immediate healthcare needs of the students with disabilities. The interview guide for the School-mothers elicited information on how SWDs access healthcare services and the challenges that SWDs go through in order to access healthcare. Finally, there was an interview guide for the healthcare providers (nurses and doctors). It elicited information on their attitude towards the students and the challenges they are confronted with when attending to SWDs. The interview data were transcribed, coded and analysed thematically. Braun and Clark (2006) six phases of qualitative data analysis was employed in analysing the data. Findings were discussed in relation to the research questions.

### **Key Findings**

1. The finding on accessibility was that physical structures of the various hospitals that were visited by SWDs were not accessible. The study found that structural obstacles, inaccessible medical equipment, toilet



facilities, doorways, staircase, rails, and signage were hindrances to the access of health care services by SWDs.

2. The finding shows that the attitudes of healthcare providers towards SWDs were good as reported by the participants including SWDs, Nurses and Doctors, and School-mothers. SWDs who were interviewed said healthcare providers showed much concern towards the healthcare needs of SWDs. Additionally, healthcare providers were calm and accommodating, friendly and welcoming.
3. The study revealed that there were lack of Sign Language Interpreters in the various hospitals visited by SWDs. Also that, their absence causes a lot of problems such as wrong prescription of drugs/medication, wrong in- take of medicine by SWDs, especially the hearing impaired.
4. The study revealed that healthcare services bill incurred by SWDs is paid by their Schools, Parents and other individuals and in some cases the SWDs themselves. The study also showed that the majority of the participants subscribed to NHIS but had a lot of challenges in using the NHIS card. This has put pressure on the various special schools because these schools' subvention do not come on time making it difficult for school authorities to cater for these students' extra cost of footing their healthcare bills.

### Conclusions

Despite the fact that the Persons with Disability Act; 2006 Act 715, section 6 and 7, the 1992 Constitution of Ghana Article 29 clause 6, SDG 3 and Section 9 of the Convention on the rights of persons living with

disabilities Act, which mandates that public places including healthcare facilities are made accessible to persons living with disabilities, there is still some challenges confronting persons living with disabilities including SWDs in their quest to access healthcare services in Ghana. These challenges range from inaccessible physical structures of healthcare facilities, communication barrier and financial constraints as revealed by the study. These challenges hinder SWDs greatly in accessing healthcare services. For instance the lack of sign language interpreters has a serious impact on the hearing impaired student, since their absence lead to wrong diagnosis and wrong medication as revealed by the study. As a result of these challenges, the academic work, social relationship and wellbeing of these students are affected.

### **Recommendations**

The following recommendations have been made based on the findings of the study.

1. The Ministries of Health and Housing need to revisit existing building regulations and policies to redesign buildings to ensure more disability friendly healthcare structures that will be accessible. The Government must enforce existing building regulations and policies to its fullest.
2. The Ministry of Health in collaboration with the Ministry of Education should make it a priority to incorporate sign language into the curriculum of nursing and medical schools. This will help bridge the communication barrier that exist between healthcare providers and SWDs especially the hearing impaired who visits the hospital. Alternatively, every healthcare facility should have Sign Language Interpreters in their staff.

3. The Ministry of Health should revise the NHIS policy to make it cover all expenses of SWDs healthcare services bills. If possible SWDs healthcare bills should be fully funded by the government.
4. Healthcare providers should be more receptive and patient towards SWDs who visit the various healthcare centres.

#### **Areas for Further Research**

Future researchers should concentrate on sign language interpretation and its effects on access to quality healthcare services among students with hearing impaired in Ghana.





## REFERENCES

- Aday, L. A., Andersen, R., & Fleming, G. V. (1980). *Health care in the U.S.: Equitable for whom?* Beverly Hills, CA: Sage
- Áfio, A. C. E., de Carvalho, L. V., Marques, J. F., de Oliveira, P. M. P., de Almeida, P. S., & Pagliuca, L. M. F. P. (2016). Physical accessibility for disabled people: Analysis of toilet facilities in primary health care units. *Open Journal of Nursing*, 6(2), 948-957.
- Amedahe, F. K. (2001). Combining teacher assessment scores with external examination scores for certification: Comparative study of four statistical models. *Ife Psychologia*, 9(1), 12-34.
- Amin, M. E. (2005). *Social science research: Conception, methodology and analysis*. Uganda: Makerere University Printing.
- Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly Health and Society*, 95-124.
- Andersen, R. M., & Davidson, P. L. (2001). Improving access to care in America: Individual and contextual indicators. In R. M, Anderson, T. H. Rice, & E. G. Kominski (Eds.), *Changing the US. health care system: Key issues in health services, policy and management* (pp.54-57), San Francisco, CA: Josey.
- Andersen, R. M. (1995). Revisiting the behavioural model and access to medical care: Does it matter? *Journal of Health and Social Behaviour*, 1-10.
- Andersen, R. (1968). A behavioural model of families' use of health services. *Journal of Health and Social Behaviour*, 36(1), 1-10

Andersen, R. M. (2008). National health surveys and the behavioural model of health services use. *Medical Care*, 46(7), 647-63.5

Anderson, O. W. (1992). *Health care: Can there be equity?* New York: Wiley.

An Action on Disability and Development (ADD) (2005). *Challenges faced by people with disabilities (PWDs) in utilizing HIV/AIDS communication and Related Health Services in Uganda*. Uganda: Health Services.

Angus, J. E, Lombardo, A. P., Lowndes, R. H., Cechetto, N., Ahmad, F., & Bierman, A. S. (2013). Beyond barriers in studying disparities in women's access to health services in Ontario, Canada: A qualitative meta-synthesis. *Qualitative Health Research*, 23(4), 476-494.

Al-Abdulwahab, S., & Al-Gain, S. (2003). Attitudes of Saudi Arabian health care professionals towards people with physical disabilities. *Asia Pacific Disability Rehabilitation Journal*, 14(1), 63-70.

Alexa, K., Paul, F., & Johannes, F. (2016). Healthcare access among deaf people. *The Journal of Deaf Studies and Deaf Education*, 21(1), 1-10.

Apoya, P., & Marriott, A. (2011). Achieving a shared goal, free universal health care in Ghana: Alliance for reproductive health rights, essential services platform, ISODEC, Oxfam international.

Aldersey, H. M. (2012). Family perceptions of intellectual disability: Understanding and support in Dar es Salaam. *African Journal of Disability*, 1(1), 12-27.

Arooj, A., Malik, A. N., & Siddiqi, F. A. (2013). Professional and personal attitude of medical students towards disabled persons. *Rawal Medical Journal*, 38(4), 332-334.

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen's behavioural model of health services use: A systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine*, 9, 231-238.

Babbie, E., & Mouton, J. (2006). *The practice of social research*. Cape Town: Oxford University Press.

Badu, E. (2014). *Healthcare accessibility barriers confronting persons with disabilities in the Kumasi metropolis*. Unpublished master's thesis, Kwame Nkrumah University of Science and Technology, Kumasi.

Badu, E., Opoku, M. P., Appiah, S. C. Y., & Agyei-Okyere, E. (2015). Financial access to healthcare among persons with disabilities in the Kumasi metropolis, Ghana. *Disability, Community Based Rehabilitation and Inclusive Development*, 26(2), 47-64.

Badu, E., Agyei-Baffour, P., & Opoku, M.P (2016). Access barriers to health care among people with disabilities in the Kumasi metropolis of Ghana. *Canadian Journal of Disability Studies*, 2(12), 234-242.

Barnett, S., & Franks, P. (2002). Health care utilization and adults who are deaf: Relationship with age at onset of deafness. *Health Services Research-Chicago*, 37(1), 105-120.

Besten, J. D., Cornielje, M. T., Cornielje, H., & Botwey, D., N. (2016). Supporting parents in caring for children with disability in Ghana. *Disability, Community Based Rehabilitation and Inclusive Development*, 27(3), 112-132.

Brocklehurst, R., & Costello, J. (2003). Health inequalities: The black report and beyond. In J. C. A. M. Haggart (Eds.). *Public health and society* (pp. 46-50), New York: Palgrave Macmillan.



Brofenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard: Harvard University Press.

Breakwell, G. M., Hammond, S., Fife-Schaw, C., & Smith, J. A. (2006). *Research methods in psychology* (3<sup>rd</sup> ed.) London: Sage Publication.

Brink, H. I. L. (1993). Validity and reliability in qualitative research. *Curation*, 16(2), 35-38.

Burke, J. (2013). Just for the fun of it: Making playgrounds accessible to all children. *World Leisure Journal*, 55(1), 83-95.

Braun, V., & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Burcu, A. (2000). A comparison of two data collecting methods: Interviews and questionnaires. *Hacettepe Üniversitesi Eğitim Fakültesi Dergisi*, 18, 1-10.

Cohen, L., Manion, L., & Morrison, K. (2000). *Research methods in education* (5<sup>th</sup> Ed). London: Routledge Falmer.

Coleridge, P. (1993). *Disability, liberation and development*. Ireland: Oxfam Publishers.

Connard, C., & Novick, R. (1996). *The ecology of the family: A background paper for a family-centered approach to education and social service delivery: Child, family, and community programme*. Retrieved from <http://www.nwrel.org/cfc/publications/ecology2.html>.

Convention on the rights of persons with disabilities (2006). *United nations convention on the rights of persons with disabilities* Retrieved from <http://www.un.org/esa/socdev/enable/rights/convtexte.htm>.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2<sup>nd</sup> ed.). Thousand Oaks, California: Sage.

Creswell, J.W. (2009). *Research designs: Qualitative, quantitative, and mixed method approaches* (2<sup>nd</sup> ed.). Thousand Oaks: CA, Sage.

Cupples, M. E., Hart, P. M., Johnston, A., & Jackson, A. J. (2012). Improving healthcare access for people with visual impairment and blindness. *British Medical Journal*, 344(784), 42-46.

Danso, A. K., Ayarkwa, J., & Dansoh, A. (2011). State of accessibility for the disabled in selected monumental public buildings in Accra. *The Ghana Surveyor*, 1-19.

De Benedictis, I. (2014). *Attitudes of physiotherapy students towards people with disabilities: The effects of the curriculum of the Satakunta University of Applied Science*. Unpublished master's thesis, University of Applied Science, Satakunta.

Deem, R. (2002). Talking to manager-academics: Methodological dilemmas and feminist research strategies. *Journal of the British Sociological Association, Sociology*, 36, 835-855.

Denzin, N., & Lincoln, Y. (2005). *Handbook of qualitative research* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.

DeJong, G., Palsbo, S. E., & Beatty, P. W. (2002). The organisation and financing of health services for persons with disabilities. *Milbank Quarterly*, 80(2), 261-301.

Drainoni, M. L., Lee-Hood, E., Tobias, C., Bachman, S. S., Andrew, J., & Maisels, L. (2006). Cross-disability experiences of barriers to health-

care access consumer perspectives. *Journal of Disability Policy Studies*, 17(2), 101-115.

Disabled World (2009). *Health and disability news and statistics for Africa*.

Retrieved from <http://www.disabled-world.com/news/africa/>

Donnellan, C. (2001). *Disability awareness*. United Kingdom: Independence Educational Publishers.

Elwan, A. (2009). *Poverty and disability a survey of the literature*. Social Protection Discussion Paper Series: Social Protection Unit, Human Development Network, The World Bank.

Ervin, D. A., & Merrick, J. (2014). *Intellectual and developmental disability: Healthcare financing*. Retrieved from <http://www.frontiersin.org>

Frankel, J. R., & Wallen, N. E. (2003). *How to design and evaluate research in education* (2<sup>nd</sup> ed.). New York: McGraw Hill Inc.

Ganle, J. K., Otupiri, E., Obeng, B., Edusei, A. K., Ankomah, A., Adanu, R. (2016). Challenges women with disability face in accessing and using maternal healthcare services in Ghana: A qualitative study. *Plos One*, 11(6), 1-13.

Gay, L. R., Mills, G. E. & Airasian, P. (2009). *Educational research: Competencies for analysis and applications* (9th ed.). London: Pearson Education.

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The behavioural model for vulnerable populations: Application to medical care use and outcomes for homeless people. *Health Services Research*, 34(6), 12-73.



Ghana Statistical Service. (2012). *2010 population and housing census: Summary report of final results*. Accra: Ghana Statistical Service.

Grut, L., Mji, G., Braathen, S. H., & Ingstad, B. (2012). Accessing community health services: Challenges faced by poor people with disabilities in a rural community in South Africa. *African Journal of Disability, 1*(1), 7-19.

Grut, L., & Ingstad, B. (2006). This is my life-Living with a disability in Yemen: A qualitative study. *Oslo: SINTEF Health Research*.

Haricharan, H. J., Heap, M., Coomans, F., & London, L. (2013). Can we talk about the right to healthcare without language? A critique of key international human rights law, drawing on the experiences of a deaf woman in Cape Town, South Africa. *Disability and Society, 28*(1), 54-66.

Hasanzada, M. T. (2011). Study on the situation of physical accessibility of persons with disabilities to public places. *Afghanistan Independent Human Rights Commission, 2*-28.

Högberg, T. (2010). *Not in my backyard: Public attitudes towards mental illness and people with mental illness living in Sweden*. Institutionen För Klinisk Neurovetenskap/Department of Clinical Neuroscience.

Hugo, A. (2003). Australian disability clearinghouse on education and training. *Youth Studies Australia, 22*(4), 54-55.

Hwang, K., Johnston, M., Tulsy, D., Wood, K., Dyson-Hudson, T., & Komaroff, E. (2009). Access and coordination of health care service for people with disabilities. *Journal of Disability Policy Studies, 20*(1), 28-34.

Iezzoni, L. I., O'Day, B. L., Killeen, M., & Harker, H. (2006). Communicating about health care: Observations from persons who are deaf or hard of hearing. *Annals of Internal Medicine*, 140(5), 356-362.

Jacobs, E. A., Lauderdale, D. S., Meltzer, D., Shorey, J. M., Levinson, W., & Kathleen, C., & Fatata-Hall, K. (2013). Attitudes of nurses toward children with disabilities: The attitudes of nursing students toward children with disabilities: An experimental design. *International Journal of Physical Medicine and Rehabilitation*, 1, 1-15.

Kara, H. (2015). *Creative research methods in the social sciences: A practical guide*. London: Policy Press.

Kim, K., Park, Y. H., Lee, B. S., & Kim, J. Y. (2010). Comparison of the attitudes toward and contact with disabled person among health care professionals, lay persons, and disabled persons. *The Korean Journal of Rehabilitation Nursing*, 13(1), 13-22.

Kimberlin, C. I., & Winterstein, G. A. (2008). Validity and reliability of measurement instruments used in research. *American Journal of Health Systematic Pharmacology*, 65, 2276-2284.

Kroll, T., Jones, G. C., Kehn, M., & Neri, M. T. (2006). Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: A qualitative inquiry. *Health and Social Care in the Community*, 14(4), 284-293.

Kidd, M., & Purves, D. (2000). Role of information technology. In C. Silagy, & A. Haines (Eds.), *Evidence based practice in primary care* (pp. 123-125). United Kingdom: BMJ Books.

Kportufe, G. S. (2015). Assessment on the accessibility of public buildings and its facilities to the disabled in Ghana. *Assessment*, 7(10), 78-90.

Krefting, L. (1991). Riggor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 43(3), 272-281.

Khan T. M., Umar M, Naeem A., & Marryam M. (2016) Attitude of medical professionals towards persons with disabilities. *Annual Pakistan Institutional Medical Science*, 12(1), 17-20.

Lawn, J. E., Rohde, J., Susan, R., Were, M., Paul, V. K., & Chopra, M. (2008). Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalize. *The Lancet*; 37(2), 917–927.

Last, J. M. (2008). *Public health and human ecology*. London: Springer.

Lwanga-Ntale, C. (2003). *Chronic poverty and disability in Uganda*. Chronic Poverty Research Centre Working Paper. Institute of Development Policy and Management/CPRC, Manchester.

Mannan, H., & MacLachlan, M. (2013). The world report on disability and its implications for rehabilitation psychology. *Rehabilitation Psychology*, 59(2), 1-17.

Masasa, T., Irwin-Carruthers, S., & Faure, M. (2004). Knowledge of beliefs about and attitudes to disability: Implications for health professionals. *South African Family Practice*, 47(7), 40-44.

Mensah, J., Oppong, J. R., & Schmidt, C. M. (2010). Ghana's national health insurance scheme in the context of the health MDGs: An empirical evaluation using propensity score matching. *Health Economics*, 19(1), 95-106.



McLellan, E., Macqueen, M. K., & Neidig, L. J. (2003). Beyond the qualitative interviews: Data preparation and transcription. *Field Methods, 15*(1), 63-84

Muderedzi, J., & Ingstad, B. (2011). Disability and social suffering in Zimbabwe. *Disability and Poverty. A Global Challenge*, 171.

Mont, D. (2007). *Measuring disability prevalence*. World Bank Social Protection Discussion Paper, 17-26.

Morgan, S. L. & Waring, C. G. (2004). *Guidance on testing data reliability: Assessing the reliability of computer processed data*, USDA Graduate School Government Auditor Training Institute.

McNally, A., & Mannan, H. (2013). Perceptions of caring for children with disabilities: Experiences from Moshi, Tanzania. *African Journal of Disability, 2*(1), 10-27.

McEwen, A., & Kraszewski, S. (2010). *Communication skills for adult nurses*. London: McGraw-Hill International.

McFadyen, J., & Rankin, J. (2016). The role of gatekeepers in research: Learning from reflexivity and reflection. *Journal of Nursing and Health Care, 4*(1), 82-88.

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. San Francisco: Jossey-Bass.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2<sup>nd</sup> ed.). Thousand Oaks: Sage.

Mushtaq, A., Inam, A., & Abdullah, M. (2015). Attitudes of parents towards behavioural management of children with intellectual disability. *Journal of Health Psychology, 16*(4), 822-872.

Neuman, W. L. (2007). *Social research methods: Qualitative and quantitative approaches* (4<sup>th</sup> ed.). Boston: Allyn Bacon.

Nolan, Y., Moonie, N., & Lavers, S. (2005). *Health and social care*. Oxford: Heinemann Educational Publishers.

Nortey, A. D. (2009). *Barriers to social participation for the deaf and hard of hearing in Ghana*. Unpublished master's thesis, University of Bergen, Bergen.

Oliver, M. (1996). *Understanding disability: From theory to practice*. New York: Palgrave Macmillan.

Owusu, K., & Owusu-Ansah, N. B. (2011). *Designs and construction of buildings in Ghana: The disability factor*. Paper presented at the West Africa Built Environment Research (WABER) Conference 19-21 July 2011 Accra, Ghana.

Oyewole, O. O., Odusan, O., Bodunde, O. T., Thanni, L. O., Osalusi, B. S., & Adebanjo, A. A. (2017). Self-acceptance and attitude towards disability among people with disability attending a Nigerian tertiary health facility. *British Journal of Medicine and Medical Research*, 21(3), 1-10.

Patel, J. V., Gill, P. S., Chackathayil, J., Ojukwu, H., Stemman, P., Sheldon, L., & Hughes, E. A. (2011). Short-term effects of screening for cardiovascular risk in the deaf community: A pilot study. *Cardiology Research and Practice*, 493-546.

Persons with Disability Act, (2006). *Act 715*. Accra: Commonwealth Human Rights Initiative.

The constitution of the Republic of Ghana (1992). *Article 29*. Accra: Judicial Service of Ghana.

Perecman, E., & Curran, S. R. (2006). *A handbook for social science field research: Essays and bibliographic sources on research design and methods*. Thousand Oaks, London: Sage Publications.

Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences*, 1136(1), 161-171.

Preker, A. S., & Carrin, G. (2004). *Health financing for poor people: Resource mobilization and risk sharing*. London: World Bank Publications.

Polit, D. E., & Hungler, B. P. (1999). *Nursing research: Principles and methods* (5<sup>th</sup> ed.). Philadelphia. J. B. Lippincott Company.

Rimmer, J. H., Riley, B., Wang, E., Rauworth, A., & Jurkowski, J. (2004). Physical activity participation among persons with disabilities: Barriers and facilitators. *American Journal of Preventive Medicine*, 26(5), 419-425.

Rossmann, G. B., & Rallis, S. F. (2003). *Learning in the field: An introduction to qualitative research*. Thousand Oaks, CA: Sage Publications.

Saunders, M. L. (2006). *Research methods for business students*. London: Sage.

Saunders, M., Lewis, P. & Thornhill, A. (2012). *Research methods for business students* (4<sup>th</sup> ed.). Harlow: FT Prentice Hall.



Setchidanand, N., Gunukula, S. K., Lam, W. Y., McGuigan, D., Symons, A. B., Matthew, W., & Elie, A. A. (2016). Attitudes of healthcare students and professionals toward patients with physical disability: A systematic review. *American Journal of Physical Medicine and Rehabilitation*, 9(1), 533-545.

Seaman, M. A. (1991). *A Monte Carlo examination of non-parametric multiple comparison procedures for pairwise tests of location*. Chicago: IL.

Stephenson, R., & Hennink, M. (2004). Barriers to family planning use amongst the urban poor in Pakistan. *Opportunities and Choices Working Paper*, 2(1), 1-34.

Sommers, R. & Sommers, B. (2002). *A practical guide to behavioural research tools and techniques*. New York: Oxford University Press.

Sowney, M., & Barr, O. (2004). Equity of access to health care for people with learning disabilities: A concept analysis. *Journal of Learning Disabilities*, 8(3), 247-265.

Shaikh, B. T., & Hatcher, J. (2005). Health seeking behaviour and health service utilization in Pakistan: Challenging the policy makers. *Journal of Public Health*, 27(1), 49-54.

Singer, R. F., Dickman, I., & Rosenfield, A. (2017). *Increasing the physical accessibility of health care facilities*. Retrieved from [www.cms.gov](http://www.cms.gov)

Schneider, M., Eide, A. H., Amin, M., MacLachlan, M., & Mannan, H. (2013). Inclusion of vulnerable groups in health policies: Regional policies on health priorities in Africa. *African Journal of Disability*, 2(1), 9-11.

Steinberg, A. G., Barnett, S., Meador, H. E., Wiggins, E. A., & Zazove, P. (2006). Health care system accessibility. *Journal of general internal medicine, 21*(3), 260-266.

Sheridan, M. (2001). *Inner lives of deaf children: Interviews and analysis*. Washington DC: Gallaudet University Press.

Shimahara, N (2013). *Anthro-ethnography: A methodological consideration in qualitative research*. Lincoln: Nebraska Press.

Taylor, C., & Gibbs, G. R. (2010). What is qualitative data analysis (QDA)? *Research in Post Compulsory Education, 14* (1), 31-41.

Thaddeus, S., & Maine, D. (1990). *Too far to walk: Maternal mortality in context findings from a multidisciplinary literature review*. New York: Columbia University.

Thew, D., Smith, S. R., Chang, C., & Starr, M. M. (2012). The deaf strong hospital program: A model of diversity and inclusion training for first-year medical students. *Academic Medicine Journal of the Association of American Medical Colleges, 87*(11), 14-96.

The Office of the Surgeon General (2005). *Table AA6: Number of children served under IDEA, part b by disability and age group during the 2000-01 school years*. Retrieved from [http://www.Ideadata.org/arc\\_toc2.html](http://www.Ideadata.org/arc_toc2.html)

Thisted, R. A. (2001). Impact of interpreter services on delivery of health care to limited-English proficient patients. *Journal of General Internal Medicine, 16*(7), 468-474.

Tomlinson, M., Swartz, L., Officer, A., Chan, K. Y., Rudan, I., & Saxena, S. (2009). Research priorities for health of people with disabilities: An expert opinion exercise. *The Lancet*, 374(9704), 1857-1862.

Tomlinson, M., Swartz, L., Officer, A., Chan, K. Y., Rudan, I., & Saxena, S. (2009). Research priorities for health of people with disabilities: an expert opinion exercise. *The Lancet*, 374(9704), 1857-1862

United Nations. (2006). Convention on the rights of persons with disabilities and optional protocol. In United Nations (Ed.). New York: United Nations.

United Nations Department of Public Information. (1994). *The standard rules on the equalization of opportunities for persons with disabilities*: United Nations.

Vander M. L. (1999). Women in academic departments: Uneasy roles, complex relationships. In J. B. Bennett & D. J. Figuli, (Eds.). *Enhancing departmental leadership: The roles of the chairperson*, (pp.61- 71). New York: MacMillan Publishing Company.

Vanderpuye, I. (2013). Piloting inclusive education in Ghana: Parental perceptions, expectations and involvement. Unpublished doctoral dissertation, School of Education, The University of Leeds.

Vergunst, (2016). *Access to health care for persons with disabilities in rural Madwaleni, Eastern Cape, South Africa*. Unpublished PhD. dissertation, Stellenbosch University, South Africa.

Wilson, T., Hoffmann, P., Somasundaran, S., Kessler, J., Wiebe, J., Choi, Y. & Patwardhan, S. (2005). Opinion finder: A system for subjectivity



analysis. In *proceedings of hlt/emnlp on interactive demonstrations* (pp. 34-35). Association for Computational Linguistics.

World Health Organization. (2011). *World report on disability*: World Health Organization.

World Health Organization. (2016). *World report on disability*: World Health Organization.

World Health Organization (2013). *Disability and health*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs352/en/>

World Bank (2012). *Internet users*. Retrieved from <http://www.data.worldbank>

Xu, K., Evans, D. B., Kadama, P., Nabyonga, J., Ogwal, P. O., Nabukhonzo, P., & Aguilar, A. M. (2006). Understanding the impact of eliminating user fees: Utilization and catastrophic health expenditures in Uganda. *Social Science and Medicine*, 62(4), 866-876.

Yıldırım, S., & Candan, B. (2015). Segmentation of green product buyers based on their personal values and consumption values. *Environmental Values*, 24(5), 641-661.

Zazove, P., Niemann, L. C., Gorenflo, D. W., Carmack, C., Mehr, D., Coyne, J. C., & Antonucci, T. (1993). The health status and health care utilization of deaf and hard-of-hearing persons. *Archives of Family Medicine*, 2, 745-752.

**APPENDIX A**  
**UNIVERSITY OF CAPE COAST**  
**FACULTY OF EDUCATIONAL FOUNDATIONS**  
**HEALTHCARE SERVICE INVENTORY FOR STUDENTS WITH**  
**DISABILITIES**

*Thank you very much for your time and interests in this study. This interview schedule is designed to seek views and perceptions concerning access to healthcare services among students with disability. You are being invited to respond to some questions in order to know your views on the issues. The study is purely for academic purposes and that all the information that you provide will be confidential. For more information and details about the study, please contact Eric Abodey, (+2330246289287, [onevc2010@yahoo.com](mailto:onevc2010@yahoo.com) /[eric.abodey@stu.ucc.edu.gh](mailto:eric.abodey@stu.ucc.edu.gh)).*

The following protocol will help to guide the methodology and logistics of conducting the research – mainly in-depth interviews with students with disability with respect to their access to healthcare services.

**Interview consent**

- General consent protocol
  - Objective of research
  - Nature of participation explained
  - Statements to be read:
    - No obligation
    - Free to leave/stop at any time
    - Identity kept anonymous and information kept private
    - Pictures used only with consent

- Signature of participant/verbal agreement (recorded by 3<sup>rd</sup> party/interpreter)
- Consent protocol for minors (under 18)
  - Signature/verbal consent of participant
  - Signature of caretaker/verbal consent (above 18)

## **INTERVIEW GUIDE FOR STUDENTS WITH DISABILITIES**

### **INTRODUCTION**

### **BIOGRAPHIC DATA**

1. What is your gender?
2. What age range do you fall in?

18-20

20-25

25-30

3. What is your class and programme of study?
4. Which hospital do you visit?
  - 4b. Apart from this hospital, is there any other hospital you visit?

### **ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH**

### **CARE FACILITIES**

5. Describe how you get to the hospital from your house?
6. How accessible is the route from the parking or bus stop into the hospital buildings?
7. How difficult is it accessible to the entry doors to the hospital?
8. What obstacles/ hindrances/ impediments do you enter on the walkways to the various departments?
9. What types of signals are provided for the visually impaired?



## ATTITUDE OF HEALTHCARE PROVIDERS

10. How do the healthcare providers welcome you to the hospital?
11. Has there been an instance that a healthcare provider refused to attend to your health care needs?
  - 12b. Could you tell me more about why this was the case and what you did?

12. Have you ever experienced any verbal/physical/sexual abuse from a healthcare provider? **YES/NO**

- 13b. Could you cite some specific examples of such cases?

13. Describe the attitude of health care providers towards students with disabilities who visit the facility.

## AVAILABLE SUPPORT SERVICES AT THE HOSPITAL

14. What special support services are given to SWDs at the hospital you visited?
15. Are there any sign language interpreters at the hospitals?
16. How useful were the sign language interpreters when you visited the hospital?
17. How do you get your medical cards processed at the OPD?

## FINANCIAL ACCESSIBILITY TO HEALTHCARE

18. How are you able to finance the transport cost from your school to hospital? Probe on the (role of family, networks, friends, NGOs etc)
19. How do you pay your hospital bills?
20. Are you registered under the National Health Insurance Scheme?
21. How was the initial registration fee paid?
22. How is the renewal of the NHIS paid when it is expired?

23. What are the challenges/difficulties in using the NHIS as a student with disability?

Is the NHIS readily accepted when taken to the hospital?

24. Has there been any instance where your healthcare bills were not paid? YES/NO

**If YES**

Tell me more on what happened when you couldn't pay and what you did?

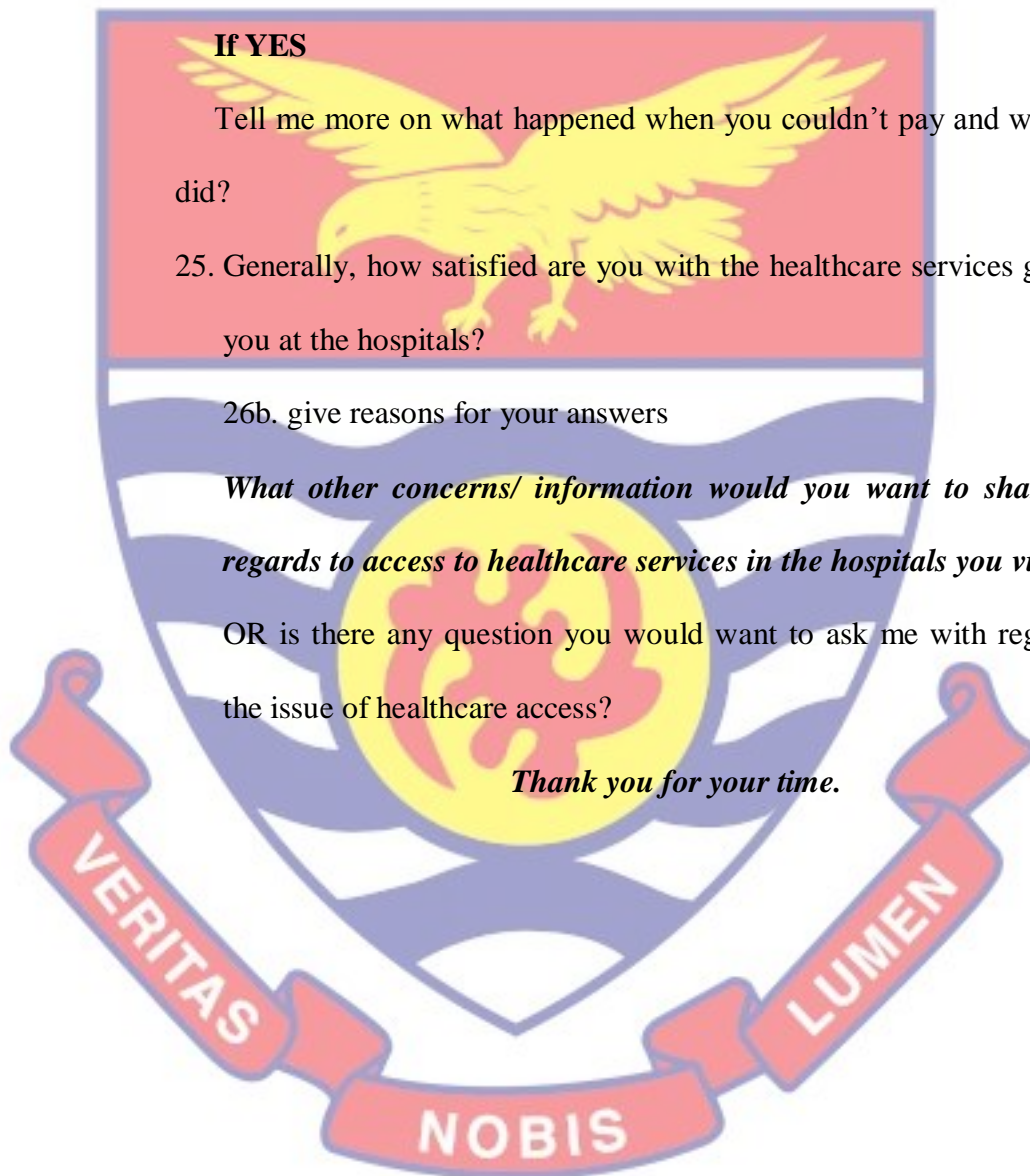
25. Generally, how satisfied are you with the healthcare services given to you at the hospitals?

26b. give reasons for your answers

*What other concerns/ information would you want to share with regards to access to healthcare services in the hospitals you visit?*

OR is there any question you would want to ask me with regards to the issue of healthcare access?

*Thank you for your time.*



## APPENDIX B

### UNIVERSITY OF CAPE COAST

#### FACULTY OF EDUCATIONAL FOUNDATIONS

#### INVENTORY FOR HEALTHCARE PROVIDERS

*Thank you very much for your time and interests in this study. This interview schedule is designed to seek views and perceptions concerning access to healthcare services among students with disability. You are being invited to respond to some questions in order to know your views on the issues. The study is purely for academic purposes and that all the information that you provide will be confidential. For more information and details about the study, please contact Eric Abodey, (+2330246289287, [onevc2010@yahoo.com](mailto:onevc2010@yahoo.com) /[eric.abodey@stu.ucc.edu.gh](mailto:eric.abodey@stu.ucc.edu.gh))*

#### **BIOGRAPHIC DATA**

1. What is your position in this hospital?
2. How long have you been working here as a nurse/Medical Doctor?

#### **ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH CARE FACILITIES**

3. What types of SWDs/PWDs visit the hospital more frequently?
4. How accessible is this hospital building to SWDs?
5. What obstacles/ hindrances/ impediments do students with disabilities encounter on the walkways to the various departments in the hospitals?
6. What efforts/strategies/plans have been made or are in place to deal with each of the identified obstacles/impediments



7. What types of signs/signals are provided for the visually impaired?

#### **ATTITUDE OF HEALTHCARE PROVIDERS**

8. How do you welcome students with disabilities to the hospital?

9. What will make you refuse to attend to SWDs?

10. How will you describe the care given to SWDs when they visit the hospital?

11. How challenging is it to you when attending to SWDs?

#### **AVAILABLE SUPPORT SERVICES AT THE HOSPITAL**

12. What special support services are available to SWDs who visit the hospital?

13. Are there sign language interpreters at the hospitals?

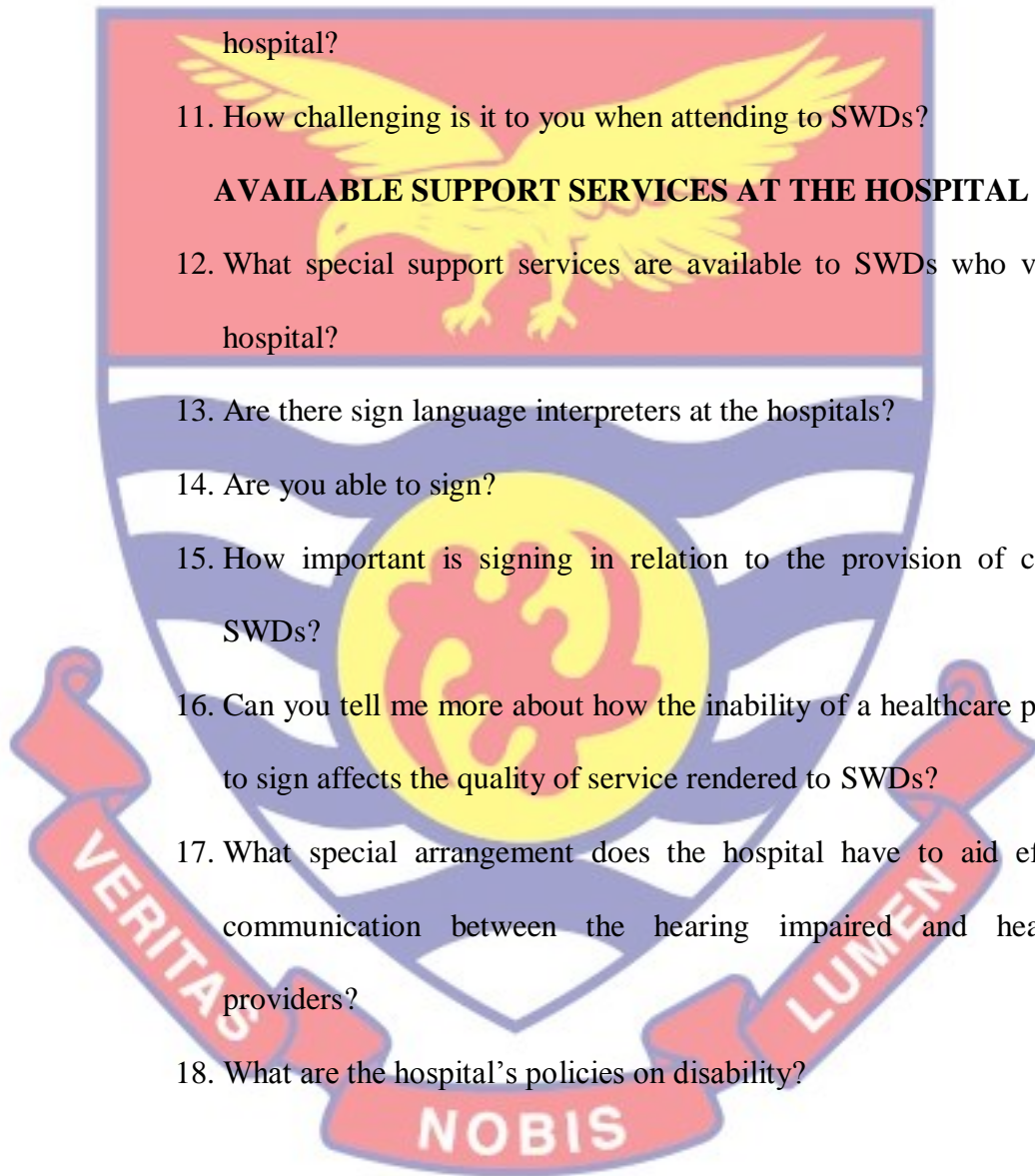
14. Are you able to sign?

15. How important is signing in relation to the provision of care for SWDs?

16. Can you tell me more about how the inability of a healthcare provider to sign affects the quality of service rendered to SWDs?

17. What special arrangement does the hospital have to aid effective communication between the hearing impaired and healthcare providers?

18. What are the hospital's policies on disability?



## APPENDIX C

### UNIVERSITY OF CAPE COAST

#### FACULTY OF EDUCATIONAL FOUNDATIONS

#### HEALTHCARE SERVICE INVENTORY FOR SCHOOL-MOTHERS

*Thank you very much for your time and interests in this study. This interview schedule is designed to seek views and perceptions concerning access to healthcare services among students with disability. You are being invited to respond to some questions in order to know your views on the issues. The study is purely for academic purposes and that all the information that you provide will be confidential. For more information and details about the study, please contact Eric Abodey, (+2330246289287, [onevc2010@yahoo.com](mailto:onevc2010@yahoo.com) /[eric.abodey@stu.ucc.edu.gh](mailto:eric.abodey@stu.ucc.edu.gh)).*

The following protocol will help to guide the methodology and logistics of conducting the research – mainly in-depth interviews with students with disability with respect to their access to healthcare services.

#### **Interview consent**

- General consent protocol
  - Objective of research
  - Nature of participation explained
  - Statements to be read:
    - No obligation
    - Free to leave/stop at any time
    - Identity kept anonymous and information kept private
    - Pictures used only with consent

- Signature of participant/verbal agreement (recorded by 3<sup>rd</sup> party/interpreter)
- Consent protocol for minors (under 18)
  - Signature/verbal consent of participant
  - Signature of caretaker/verbal consent (above 18)

#### **BIOGRAPHIC DATA**

- 26. What is your gender?
- 27. Please how old are you?
- 28. What is your level of education?
- 29. How long have been serving as a house mother?
- 30. Which hospital do you take the children to when they are sick?

#### **ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH CARE FACILITIES**

- 31. Describe how you get the sick child to the hospital from your school?
- 32. How accessible is the route from the parking or bus stop into the hospital buildings?
- 33. How difficult is it accessible to the entry doors to the hospital?
- 34. What obstacles/ hindrances/ impediments do you enter on the walkways to the various departments in the hospitals?
- 35. What types of signals are provided for the visually impaired?

#### **ATTITUDE OF HEALTHCARE PROVIDERS**

- 36. How do the healthcare providers welcome you take the sick child to the hospital?
- 37. Has there been an instance where a healthcare provider refused to attend to a sick child you took to the hospital?



38. Has any of your children ever experienced any verbal/physical/sexual abuse from a healthcare provider when you him/her to the hospital?

39. How will you describe the attitude of health care providers towards students you take to the hospital?

#### **AVAILABLE SUPPORT SERVICES AT THE HOSPITAL**

40. What special support services are given to SWDs at the hospital you have been taken the children to?

41. Are there any sign language interpreters at the hospitals to have been taken the students to?

42. How do you get the medical cards of the children processed of at the OPD?

#### **FINANCIAL ACCESSIBILITY TO HEALTHCARE**

43. How are you able to finance the transport cost from your school to hospital? Probe on the (role of family, networks, friends, NGOs etc)

44. How do you pay the hospital bills of the children you have been taken to the hospital?

45. Are the children registered under the National Health Insurance Scheme?

46. How was the initial registration fees paid?

47. How is the renewal of the NHIS of the children paid when it is expired?

48. What are the challenges/difficulties in using the NHIS as a student with disability?

49. Has there been an instance where the healthcare bills a child were not paid?

If yes, what did you do?

50. Generally, how satisfied are you with the healthcare services given to the children at the hospitals?

51. What other concerns/ information would you want to share with regards to access to healthcare services in the hospitals you take the children to?



## APPENDIX D

### A SAMPLE OF TRANSCRIBED DATA OF A STUDENT (13)

#### BIOGRAPHIC DATA

1. What is your gender?  
*male*
2. What age range do you fall in?  
*25-30*
3. Which hospital do you visit?  
*Ve-kolenu Eye Clinic*  
*Kpando municipal hospital*  
*Hohoe municipal hospital*

#### ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH CARE FACILITIES

4. Describe how you get to the hospital from your house?  
*I'm led by my step mother to the hospital*
5. How accessible is the route from the parking or bus stop into the hospital buildings?  
*There is much challenge with the covers on the gutters. The road is not corresponding to the gutters. The gutters are not well covered. Covers connecting the entrance of the hospital is not well cemented so I have to drag my legs in the pebbles to picture how it's before I get there.*
6. How difficult is it accessible to the entry doors to the hospital?  
*The doors are opened, the ones that are closed have holder and I have to either push or pull before I enter.*
7. What obstacles/ hindrances/ impediments do you enter on the walkways to the various departments?  
*The position of the chairs and tables that are set to inspect peoples NHIS and folders make it more difficult when going through the hospitals. The direction of the walkway to the various places makes it difficult the consulting rooms.*



8. What types of signals are provided for the visually impaired?

*All the hospital I have visited have some. They have directional sound that tells you where you have gotten to. When you enter the room the sound comes in again to tell you that you are in this room (Ve-koleneu Eye Clinic hospital). There is also a security there that tells you that you are here or there.*

#### **ATTITUDE OF HEALTHCARE PROVIDERS**

9. How do the healthcare providers welcome you to the hospital?

*At the OPD, they are very rude. Let me say they are very rude.ie Hohoe municipal hospital. After taken my particulars to the eye clinic itself at the Hohoe hospital, the nurses there are clam. They gave me the details I want, how far the eye can take me n what I can do to extend it if I want. At OPD the nurses there are very rude but in the Eye Clinic itself, the nurses are calm.(the way they welcome you, the way they talk makes me describe them as been rude) .Let say the first time I visited them I dropped my NHIS card in the box, there are a lot of NHIS in the box so i was waiting for them to call me but they didn't but they called all those who came after me n when I consulted them that I have been here for some time now, they told me that it's not my turn and if I can't wait I should go home.it was one of my friends who came and said to the nurses that I'm haven a challenge with my eyes, and one of the nurses came and said so if I can't see can't I can't reason? So one of the doctors came and took my card and processed it for me.*

10. Has there been an instance that a healthcare provider refused to attend to your health care needs?

*No*

11. Have you ever experienced any verbal/physical/sexual abuse from a healthcare provider? *Apart from the Hohoe Municipal hospital where the nurse was rude to me, I have not come across before.*

12. Describe the attitude of health care providers towards students with disabilities who visit the facility.

*Let me say 90% of them are good. If they get to know you are Visually Impaired they give you the needed attention you need. Most at times when my friends visit the hospital they give them treatment for free*

#### **AVAILABLE SUPPORT SERVICES AT THE HOSPITAL**

13. What special support services are given to SWDs at the hospital you visited?

*At e Ve-kolenu hospital they have because they are specially trained n hv all the machines needed to attend to you.*

14. Are there any sign language interpreters at the hospitals?

*At the Hohoe hospital before you enter the childrens ward, they are there.*

15. How do you get your medical cards processed at the OPD?

*Normally I have to join the queue for about 2 to 3hrs.if I'm lucky one of them will pick it n say im vi n they will do it fr me.*

#### **FINANCIAL ACCESSIBILTY TO HEALTHCARE**

16. How are you able to finance the transport cost from your school to hospital? Probe on the (role of family, networks, friends, NGOs etc)

*Actually, I don't go to hospital when im in school only when Im in house I will tell my father*

17. How do you pay your hospital bills?

*My father*

18. Are you registered under the National Health Insurance Scheme?

*My father*

19. How was the initial registration fee paid?

*No family support. its my father*

20. How is the renewal of the NHIS paid when it is expired?

*My father*

21. What are the challenges/difficulties in using the NHIS as a student with disability?

Is the NHIS readily accepted when taken to the hospital?

*The only challenge I had was when I didn't have the NHIS card one day and I was asked to pay 45 cedis.*

22. Has there been any instance where your healthcare bills were not paid?

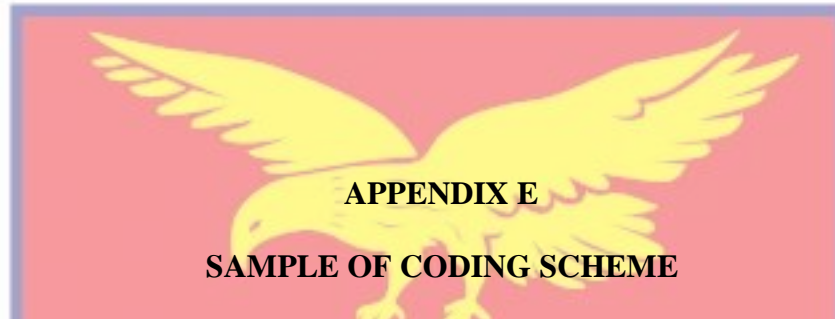
*No no*

Generally, how satisfied are you with the healthcare services given to you at the hospitals?

*For the Hohoe hospital I'm not satisfy 70% because of my condition.*

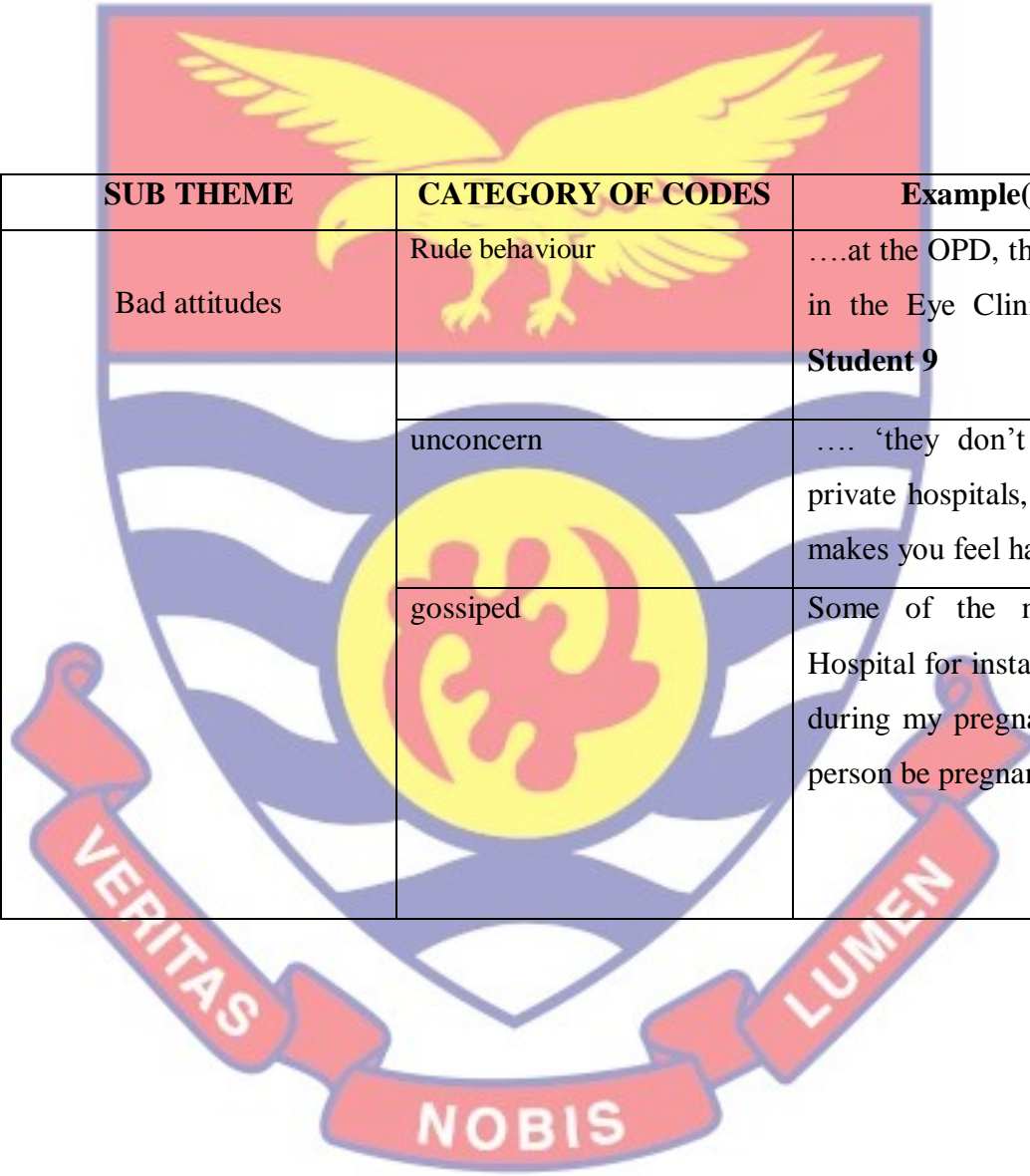
*The 70 comes as result of been in this situation. The left eye started when I was in class six when a guy used catapult to hit it. And I visited the hospital and a nurse gave us syrup and eye drop and she said everything is alright. After one year I couldn't see anything so when I visited the Kpando Eye Clinic and the Doctor said it's the Hohoe hospital that deceived us. They gave us wrong information. We were not given the right information. The second eye too, when i visited them and they treated everything and told me with the medicine everything will be alright. So as I was using the medicine, you know glaucoma is in such a way that it deals with pressure.so the pressure was increasing but they didn't gv me any medicine to reduce it, so quickly my father suggested we visit Ve-kolenu eye clinic, so when we visited it the doctor said e nurses at Hohoe hospital deceived us, they were supposes to have sent us that straight away to for the right medication for the reduction of the pressure of the glaucoma. For Hohoe hospital I'm not satisfied but for the others I'm okay. i may say I can't say its either good or bad because Hohoe deceive, Ve-kolenu and Kpando tells me the truth.so if I bring all together I think the Ve-kolenu and Kpando I'm satisfied with them.*





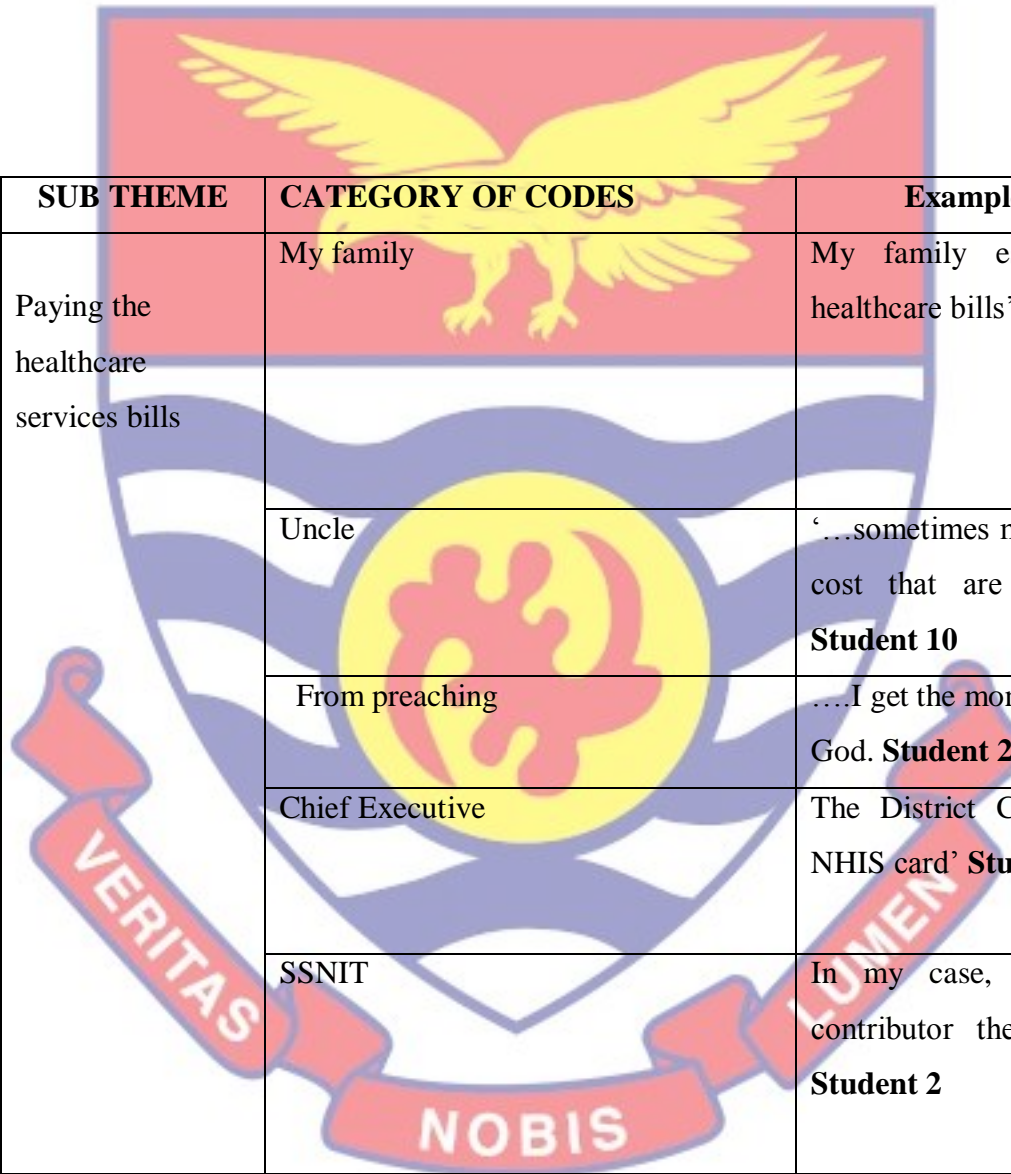
MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
<p style="text-align: center;"><b>ACCESSIBILITY OF PHYSICAL STRUCTURE OF HEALTHCARE FACILITIES TO SWDS.</b></p>	<p style="text-align: center;">Nature of roads leading to the hospital</p>	Is a bad road	<p><b>Student 12</b> said: is a bad road, because when we going, the car will be jerking</p>
		The road is not corresponding	<p>...The road is not corresponding to the gutters. The gutters are not well covered (<b>Student 13</b>).</p>
		rough and bushy	<p>...Some of the roads are rough and bushy (<b>Student 10</b>).</p>
		Road is not good	<p>The road is not good (<b>School-mother 3</b>)</p>
		Hospital is tarred	<p>The road leading to the hospital is tarred (<b>Student 15</b>)</p>

MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
The attitudes of healthcare providers towards students with disabilities	Good attitudes	Treat us well	I treat them as any other person knowing their conditions; any necessary help that I can offer them I do it. <b>HCP 12.</b>
		They welcome us well	‘They are very friendly, and when you go there they welcome you nicely.’ <b>Student 17</b>
		Accommodating	‘...some are accommodating while others are hostile. <b>Student 2</b>
		Their attitude is good	I don’t think we are rude to them, normally when we see the person has disability it touches you to help them. <b>HCP 2</b>
		They behave well	They always behave well towards me; they have good character and have enough time to listen to my problem’. <b>Student 16</b>



MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
	Bad attitudes	Rude behaviour	....at the OPD, the nurses there are very rude but in the Eye Clinic itself, the nurses are calm. <b>Student 9</b>
		unconcern	.... ‘they don’t even mind you. But for the private hospitals, the way they will receive you, makes you feel happy’. <b>School-mother 1</b>
		gossiped	Some of the nurses at (Obrooboi) District Hospital for instant gossiped when I visited there during my pregnancy, saying how could a blind person be pregnant. ( <b>Student 7</b> )



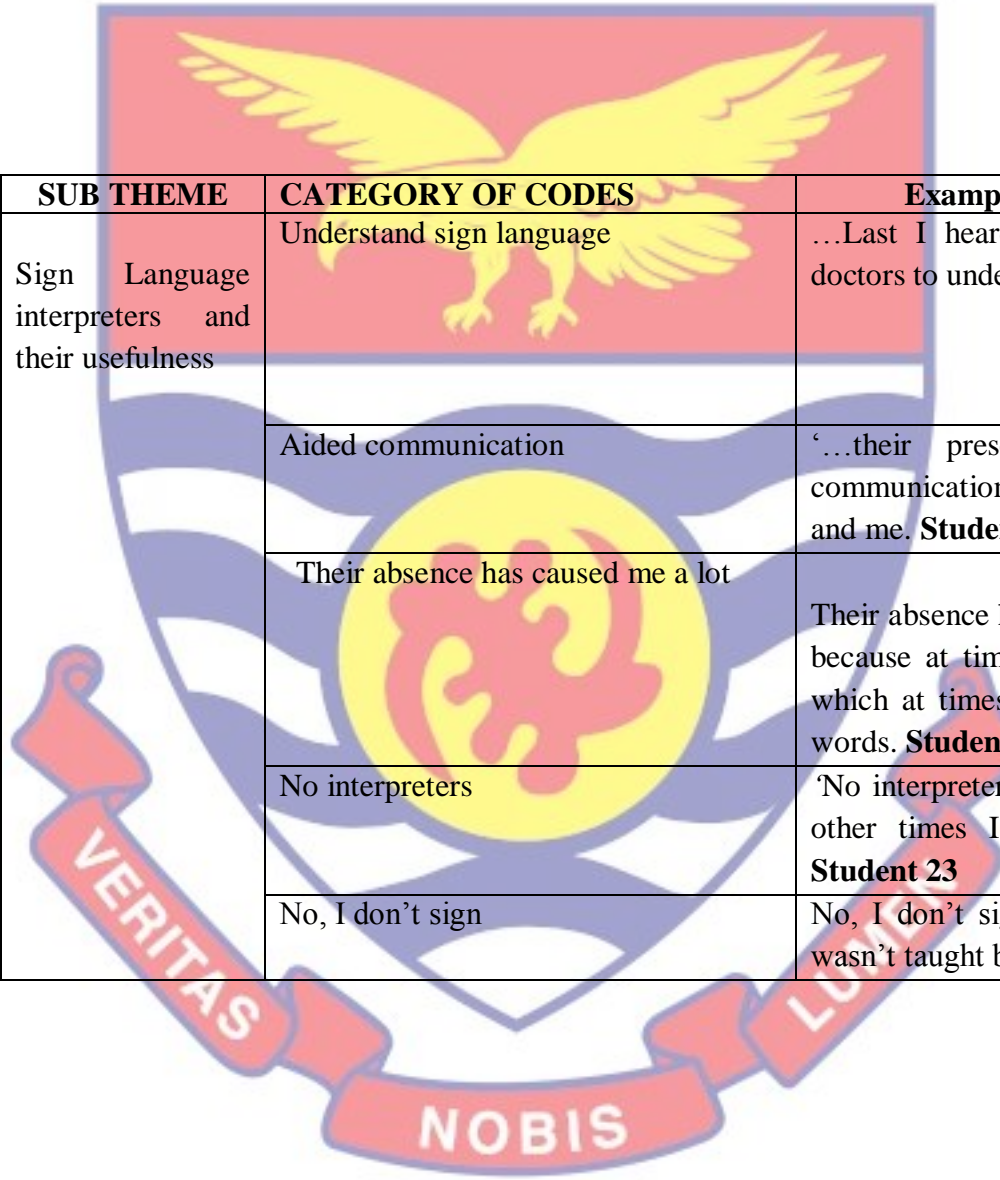


MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
Sources of finance/funding of SWDs	Paying the healthcare services bills	My family	My family especially my sisters pay my healthcare bills' <b>Student 6.</b>
		Uncle	'...sometimes my Uncle helps in paying the cost that are incurred at the hospital' <b>Student 10</b>
		From preaching	....I get the money form preaching the word of God. <b>Student 25</b>
		Chief Executive	The District Chief Executive renews my NHIS card' <b>Student 15</b>
		SSNIT	In my case, because I was a SSNIT contributor they deduct it from source' <b>Student 2</b>

MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
	Challenges with the use of NHIS	Acquiring the card	'Acquiring the card is tedious, because the process is long' <b>Student 5</b>
		Expensive drug	...they will tell you the drug they are given you isn't covered by the NHIS so you have to go and buy it elsewhere' <b>Student 12.</b>
		Cheap drug	The challenge is that you do not get the best drugs, those you get are just some cheap drugs. <b>Student 14</b>
		Medicine not available	....they will say that kind of medicine is not available but the truth is some will be there. <b>School-mother 1</b>

MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
	General satisfaction of healthcare services	asthmatic patients do not pay	‘...in my district asthmatic patients do not pay for the drug due to that I am satisfied’ <b>Student 14.</b>
		Treat us equally	...the Nurses and Doctor treat us equally as other patients’ <b>Student 17.</b>
		Not up to standard	‘...the attitude of healthcare providers was not good; drugs given were not effective and not up to standard’ <b>Student 21</b>
		I have issues with NHIS	....I have issues with the NHIS which doesn’t cover all our expenses when we visit the hospital. <b>Student 20</b>
		Very bad	Very bad, for me, giving them medicine should have been free. <b>School-mother 1</b>





MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
<p><b>Support services given to SWDs in the hospitals</b></p>	<p>Sign Language interpreters and their usefulness</p>	<p>Understand sign language</p>	<p>‘...Last I heard on news that they must train doctors to understand sign language’ <b>Student 14</b></p>
		<p>Aided communication</p>	<p>‘...their presence would have aided the communication between the healthcare providers and me. <b>Student 18</b></p>
		<p>Their absence has caused me a lot</p>	<p>Their absence has caused me a lot, because at times I have to write, which at times I cannot spell the words. <b>Student 19</b></p>
		<p>No interpreters</p>	<p>‘No interpreters, due to that I have to write and other times I have to go with my parents. <b>Student 23</b></p>
		<p>No, I don’t sign</p>	<p>No, I don’t sign. When I was in school it wasn’t taught by then’ <b>HCP 8</b></p>

MAIN THEME	SUB THEME	CATEGORY OF CODES	Example(s) of Response Patterns
	Support services provided by hospitals to SWDs	As for wheelchairs	As for wheelchairs yes they have it; but for the others, like sign language interpreters I have never seen any' <b>Student 11</b>
		Some equipment	'...in that hospital they told me there are some equipment that they use in helping the low vision people such as lens' <b>Student 7</b>
		Priority System	'...we have the Priority System of which I serve as the Priority nurses who minds the priority window. <b>HCP 2</b>
		Social Welfare Department	We have the Social Welfare Department in the hospital. <b>HCP 1</b>
		Seats were full	...There was an instant where I had to stand for about two hours, because the seats were full' <b>Student 3.</b>

APPENDIX F

LETTER OF INTRODUCTION FROM EFFIA NKWANTA  
REGIONAL HOSPITAL

*In case of the reply the number and the date of this letter should be quoted.*

My Ref No: EFH/GPN-3  
Your Ref No:.....

TEL NO. 031-2023151-4  
FAX NO: 233-31-2024565  
E-mail: enrh@ghana.com



EFFIA NKWANTA REGIONAL HOSPITAL  
GHANA HEALTH SERVICE  
P.O. BOX 229  
SEKONDI

23<sup>rd</sup> April 2018

TO WHOM IT MAY CONCERN

**RE: ERIC ABODEY**

The above-named person is Mphil student at the Department of Education and Psychology, university of Cape Coast.

As partial fulfillment of the programme, he is required to conduct Research on the topic "**Access to Health Service by students with Disability in Ghana**".

You are kindly requested to offer him the necessary assistance.

Thank you for your understanding on this matter.

**KWADWO KUSI BOACHIE  
(HEAD OF ADMINISTRATION)**

Kwadwo Kusi Boachie,  
Head of Administration,  
Effia Nkwanta Reg. Hospital  
Sekondi



APPENDIX G

LETTER OF INTRODUCTION FROM THE DEPARTMENT OF  
EDUCATION AND PSYCHOLOGY

UNIVERSITY OF CAPE COAST  
COLLEGE OF EDUCATION STUDIES  
FACULTY OF EDUCATIONAL FOUNDATIONS  
**DEPARTMENT OF EDUCATION AND PSYCHOLOGY**

Telephone: 233-3321-32440/4 & 32480/3  
Direct: 033 20 91697  
Fax: 03321-30184  
Telex: 2552, UCC, GH.  
Telegram & Cables: University, Cape Coast  
Email: [edufound@ucc.edu.gh](mailto:edufound@ucc.edu.gh)



UNIVERSITY POST OFFICE  
CAPE COAST, GHANA

27<sup>th</sup> March, 2018

Our Ref:

Your Ref:

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

THESIS WORK  
LETTER OF INTRODUCTION: MR. ERIC ABODEY

We introduce to you Mr. Abodey, a student from the University of Cape Coast, Department of Education and Psychology. He is pursuing Master of Philosophy degree in Special Education and is currently at the thesis stage.

Mr. Abodey is researching on the topic:

*"Access to Healthcare Services among Students with Disabilities in Ghana".*

We would be grateful if he is given all the needed assistance toward this necessary academic exercise. Please, any information provided will be treated as strictly confidential.

Thank you.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Theophilus Amuzu Fiadzomor'.

Theophilus Amuzu Fiadzomor (Mr.)  
Senior Administrative Assistant  
For: HEAD

APPENDIX H

ETHICAL CLEARANCE FROM ETHICAL REVIEW BOARD OF  
DEPARTMENT OF EDUCATION AND PSYCHOLOGY

UNIVERSITY OF CAPE COAST  
COLLEGE OF EDUCATION STUDIES  
ETHICAL REVIEW BOARD

UNIVERSITY POST OFFICE  
CAPE COAST, GHANA



Our Ref: CES-ERB/ucc.edu/18-5  
Your Ref: .....

Date: 05.04.2018

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

Chairman, CES-ERB  
Prof. J. A. Omotosho  
[jomotosho@ucc.edu.gh](mailto:jomotosho@ucc.edu.gh)  
0243784739

Vice-Chairman, CES-ERB  
Prof. K. Edjah  
[kedjah@ucc.edu.gh](mailto:kedjah@ucc.edu.gh)  
0244742357

Secretary, CES-ERB  
Prof. Linda Dzama Forde  
[lforde@ucc.edu.gh](mailto:lforde@ucc.edu.gh)  
0244786680

The bearer, Eric Abodey, Reg. No. ED/SOP/16/0001 is an M.Phil. / Ph.D. student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Access to healthcare services among students with disabilities in Ghana

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed his/~~her~~ proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

In view of the above, the researcher has been cleared and given approval to commence his/~~her~~ study. The ERB would be grateful if you would give him/~~her~~ the necessary assistance to facilitate the conduct of the said research.

Thank you.  
Yours faithfully,

Prof. Linda Dzama Forde  
(Secretary, CES-ERB)

## APPENDIX I

### ETHICAL CLEARANCE FROM CAPE COAST TEACHING

### HOSPITAL

#### RESEARCH AND DEVELOPMENT SECRETARIAT

*In case of reply the reference number  
and the date of this  
letter should be quoted*

Our Ref.: CCTH/RDS/2018/19

Your Ref.



P. O. Box CT.1363  
Cape Coast  
Tel: 03321-34010-14  
Fax: 03321-34016  
Website: [www.ccthghana.org](http://www.ccthghana.org)  
email: [info@ccthghana.com](mailto:info@ccthghana.com)

19<sup>th</sup> February 2018

Mr. Eric Abodey  
Degree Students  
University of Cape Coast  
College of Education Studies  
Faculty of Educational Foundations  
Department of Educational and Psychology  
Cape Coast

Dear Mr. Abodey,


#### **R&D SECRETARIAT'S INSTITUTIONAL APPROVAL**

The Cape Coast Teaching Hospital Research and Development Secretariat (CCTHRDS) have assessed your research topic, "Access to Healthcare Services Among Students with Disabilities in Ghana" which was submitted for institutional approval. The secretariat writes to inform you of the decision to grant you CCTH institutional approval to undertake the study at CCTH.

You are however required to submit an electronic copy of your findings from the research in the form of an abstract to the CCTHR&D Secretariat email address: [ccthresearch@gmail.com](mailto:ccthresearch@gmail.com)

Always quote our ref. identification number above in all future correspondence with us in relation to this research study.

Yours sincerely,

  
Ms. Princess G. Ofori  
(Head, Research, Monitoring & Evaluation)  
For: DIRECTOR OF ADMINISTRATION

CC. Head of OPD Sub-BMC  
DDNS of OPD sub-MBC

*As per the letter, approval  
has been given, so please  
support him by  
responding to the  
interview to the  
hospital.*

DIRECTOR OF NURSING SERVICE  
CAPE COAST TEACHING HOSPITAL  
ESTD 1982



## APPENDIX J

### A SAMPLE OF TRANSCRIBED DATA OF A SCHOOL-MOTHER (3)

#### INTERVIEW GUIDE FOR STUDENTS WITH DISABILITIES

#### INTRODUCTION

#### BIOGRAPHIC DATA

- 
1. What is your gender?  
*Female,*
  2. Please how old are you?  
*49years*
  3. What is your level of education?  
*MSLC*
  4. How long have been serving as a house mother?  
*8years*
  5. Which hospital do you take the children to when they are sick?  
*Efia Nkwanta hospital*

#### ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH CARE FACILITIES

6. Describe how you get the sick child to the hospital from your school?  
*If the child is not hyperactive, I carry him and descend to the road side and pick a taxi to Efia Nkwanta hospital, but if he has epilepsy and has been attacked and you give him the medicine and the whole day it doesn't stop then we use the school bus, and if the bus is not in I get a taxi and transport the child to the hospital.*
7. How accessible is the route from the parking or bus stop into the hospital buildings?  
*From where we alight to the health facility is easily accessible there are no gutters or whatsoever; the doors are always opened'*
8. How difficult is it accessible to the entry doors to the hospital?  
*At the psychiatry unit, the door is mostly opened to allow free entry.*

9. What obstacles/ hindrances/ impediments do you enter on the walkways to the various departments?

*In fact, in the psychiatric unit when you enter there are tables where the nurses are sited and they take the child and attend to him.*

10. What types of signals are provided for the visually impaired?

*There are no signals there*

#### **ATTITUDE OF HEALTHCARE PROVIDERS**

11. How do the healthcare providers welcome you together with the sick child to the hospital?

*To be honest, they welcome us well when they see the child they come for the child, even when the child behaves in some way they have patients for the child and attend to us.*

12. Has there been an instance where a healthcare provider refused to attend to a sick child you took to the hospital?

*Yes, I have had that experience before. it was around 11am on one faithful day when a child compliant of stomach ache and was vomiting of which the school authorities asked me to take the child to the nearby Clinic and upon arrival they said when it is 11am they don't give card. 'He is a special boy, I said' I said everything possible but they didn't attend to him. so I had to use the money I had on me and took him to a drug store where the child was given medication and the vomit ceased. Then later he was taken to the bigger hospital.*

13. Has any of your children ever experienced any verbal/physical/sexual abuse from a healthcare provider?

*No*

14. How will you describe the attitude of health care providers towards students with disabilities who visit the facility?

*I will say they love the children. I have one doctor in Efia Nkwanta, he stays around here, so most of the times if let's say the child begins to cough I call him and say doctor I beg where are you; o I'm in the house, is it the children; o yes, one of them in the morning he wasn't all that well but now it is becoming severe and immediately, he will come over. He personally volunteer to come over and attend to the*

children. He came because one day he came and said because of the nature of our work he will want to come here every 3months and do free screening for us. because he was one day passing by when one of the children's epilepsy had come and I had lifted the boy and he stood at a distant and watched me put the child in the dormitory and he also entered and saw that I had put cushion beneath the back-head of the child.so he asked me of my name and he left and when he came back, he applauded me because I go to other special schools but what you have been doing it hardly happens.so in fact they are very good. through him I have gotten to know a lot of doctors that I can call at any time, even in the night, they will ask what is happening to the child, first do this for him and I will join you soon.

#### **AVAILABLE SUPPORT SERVICES AT THE HOSPITAL**

15. What special support services are given to SWDs at the hospital you have been taken the children to?

*There are none. Even the medicine we don't get it at the hospitals and it's also expensive.*

16. Are there any sign language interpreters at the hospitals?

*I have not seen one before.*

17. How do you get the medical cards of the children processed of at the OPD?

*I do it when I take the child there. And because the child is special where you go the child must be with you. Unless may when you n the situation warrants that the child is put in bed, then I can quickly rush to the OPD and get the card for the children. If not and let's say he has a cut on the hand you would have to go with him because you don't know what might come upon him whether he would want to look for your where about and because of this you would have to go with him to the OPD unit to prepare his card. At the OPD unit, the nurses don't help at all. Unless it's an emergency situation but if you go and tell them that o nurse this is a special child, none will help you process the card or even give you preferential treatment.*



## FINANCIAL ACCESSIBILITY TO HEALTHCARE

18. How are you able to finance the transport cost from your school to hospital? Probe on the (role of family, networks, friends, NGOs etc)

*The school accountant pays but in his absences I do pay and later be refunded by the accountant.*

19. How do you pay your hospital bills?

*Again, the school pays or in an instance where I pay, I would have to present my receipt to the school for refund. There was an instance where a boy's finger had to be operated and the cost was heavy so the parents of the boy had to pay for it.*

20. Are you registered under the National Health Insurance Scheme?

*Almost all of them, but instead of their parents checking to see if the NHIS is expired or not, some of the parents don't do it. so on a day you need it most and you take it to the hospital, it is there you would realize its expired. In that case I would have to pay.*

21. How was the initial registration fee paid?

*Mostly parents*

22. How is the renewal of the NHIS of the children paid when it is expired?

*The parents do pay, but in an instance where I'm told it can be renew there and then, I call the parents to inform them about it and they also send me the money to renew it.*

23. What are the challenges/difficulties in using the NHIS as a student with disability?

*Sometimes the medicine to be given is expensive and because you are using the card they will say that kind of medicine is not available but the truth is some will be there. So sometimes when I go I tell them madam please if there is some available I'm buying it because I'm a school-mother and I can't go and queue in a different Drug-store where I wouldn't get. So quickly they will sell it to me. but with NHIS card they will say it's not available. i have had that experience on two occasions where I had to queue from 11am to 1pm at a Drug store where I couldn't get the medicine but when I returned to the hospital*

*and told them I couldn't get the drug and because they knowing that the child is hyperactive and had to carry the child to and fro. The nurse then said we have it but if you can afford it. And I told her I will buy it. So this time when I go there I tell them if they have it I will buy at the hospital, the cost of the drug is cheaper as compared to the pharmacy shops in town.*

24. Has there been any instance where your healthcare bills were not paid?

*Never*

25. Generally, how satisfied are you with the healthcare services given to you at the hospitals?

*Is good because whatever they need to do for the children I take them there, they do it. Even if the medicine is not available they will write for us and we go and buy and the child gets healed.*

*Again, whenever I go to the hospital and I incur any extra cost, the schools refunds me. There has never been an instance where my money wasn't paid.*

***What other concerns/ information would you want to share with regards to access to healthcare services in the hospitals you take the children to?***

*Let's assume that now that they have closed from school that I'm not even ready for hospital, they can fight and wound themselves and I would have to leave my food that is on fire and take that child to the hospital. You will see that you are disturbed, you are not ready to but you would have to go. Even when they are in their classroom something happens to them I don't wait till a teacher calls me, I run to their aid. I have live with them for long time and now they have become my children. Even if the teachers will attend to them it will not be like me taken care of them. i know what to do to them to make them better.*

OR is there any question you would want to ask me with regards to the issue of healthcare access?

*I want us to be given special treatment because we are special children. You see some of the children don't look like special children, so if there could be an avenue for us in such away that we could let them know that o maame nurse this is a special child so that they could have treated us earlier so that I can go back and I attend to the remaining children. By allowing us to form a queue*





## APPENDIX K

### A SAMPLE OF TRANSCRIBED DATA OF A HEALTHCARE

#### PROVIDER (HCP 1)

##### BIOGRAPHIC DATA

1. What is your position in this hospital?

*Dr. (House officer)*

2. How long have you been working here as a nurse/Medical Doctor?

*6months*

##### ACCESSIBILITY TO THE PHYSICAL STRUCTURE OF HEALTH CARE FACILITIES

3. What types of SWDs/PWDs visit the hospital more frequently?

*A few hearing impaired as well as visually impaired.*

4. How accessible is this hospital building to SWDs?

*For me honestly, I think it was purposely made not disability friendly. When you go to the access ways to the wards it has stairs that ideally, it shouldn't have been there. The wash room has no rails to aid or support them.*

5. What obstacles/ hindrances/ impediments do students with disabilities encounter on the walkways to the various departments in the hospitals?

*Like the staircase I talked about. Those who use the wheelchairs will find it difficult to navigate themselves to the consulting room.*

6. What efforts/strategies/plans have been made or are in place to deal with each of the identified obstacles/impediments

*I don't have any ideal about it but may be management is doing something about it then I'm not aware.*

7. What types of signs/signals are provided for the visually impaired?

*There is not any tactile for visually impaired. Those that are in the hospital are not meant for the disabled*

### ATTITUDE OF HEALTHCARE PROVIDERS

8. How do you welcome students with disabilities to the hospital?

*I treat them as any other person knowing their conditions; any necessary help that I can offer them I do it. Maybe a test that the person has to walk to you, knowing their conditions I sometimes have to rather walk to them and do it.*

9. What will make you refuse to attend to SWDs?

*Nothing, per the profession, we are to see all kinds of patients. If anything at all, it should rather serve as motivation to help them than to refuse.*

10. How will you describe the care given to SWDs when they visit the hospital?

*As it stands now I wouldn't say it's very good, it's something that needs improvement though we are doing our best but there is more room for improvement. The system and surrounding is favouring SWDs. For instance an x-ray situated in an office where every patient would have to go it for the service needed but if it could be wheeled to the disabled rather than they coming to it, it would have been better. I will say we are doing our best but we are not at where are supposed to be.*

11. How challenging is it to you when attending to SWDs?

*It becomes difficult when you need a test to be done but movement becomes difficult it delays your diagnosis as Medical Doctor.*

### AVAILABLE SUPPORT SERVICES AT THE HOSPITAL

12. What special support services are available to SWDs who visit the hospital?

*We hv a lift, a few sloping areas instead of the staircase where sm1 can push n pull bt we still need more.*

13. Are there sign language interpreters at the hospitals?

*I have not come across any.*

14. Are you able to sign?

*No, we are not taught how to sign in the medical schools.*

15. How important is signing in relation to the provision of care for SWDs?

*It would help if you can communicate effectively. Even if someone would sign for you it has a limit. Unlike if you could sign yourself.*

16. Can you tell me more about how the inability of a healthcare provider to sign affects the quality of service rendered to SWDs?

*Definitely, you can't communicate. Communication is very important in healthcare delivery, so in a situation where you can't communicate effectively, healthcare delivery will be affected.*

17. What special arrangement does the hospital have to aid effective communication between the hearing impaired and healthcare providers?

*Not that I know of.*

18. What are the hospital's policies on disability?

*I might be new here; probably if they have then I'm not aware of.*

19. Any other thing to say in connection to what we have discussed so far?

*I'm thinking generally in Ghana, not only in the healthcare sector alone, is a general thing in Ghana, building and infrastructure are design not to be disability friendly. Our washroom, they have climb staircase, no rails to hold onto. We need a bigger policy. But I think one of the most important areas it has to begin from the health care sector. So from healthcare sector then to the education sector and other areas.*

20. Are you not worried that sign language is not taught in the medical school?

*It would have come as a good thing. A good thing to know. Aside sign language, other languages like French ought to be taught but the at end of the day we are also looking at the amount of things we are supposed to know, the curriculum is very packed. I'm looking at it not only been restricted to the medical school, it could be part of our education system so that from JHS to SHS,*



*we have an idea about it so that by the time we get there we would have gotten to know the basis, so that even in the medical school if they are going to introduce it wouldn't affect the time we need to know about diagnoses.*

