ACCESSING HEALTHCARE IN GHANA: CHALLENGES OF AND
STRATEGIES ADOPTED BY PERSONS WITH PHYSICAL DISABILITY
IN THE ACCRA METROPOLIS

BY

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DECLARATION

I, Rachael Abrokwah, do hereby declare that this thesis is the result of my own research. This research was carried out under the supervision of Dr. Augustina Naami and Dr. Efua .E. Agyire-Tettey of Department of social work. This work has not been submitted either in part or whole elsewhere for the award of other degree. All references cited in this work have been duly acknowledged.

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DEDICATION

I dedicate this work to all Persons with Physical Disability in Ghana, the Ghana Blind Union, the Ghana Society for the Physically Disabled and the Ghana National Association for the Deaf.
ACKNOWLEDGMENT

First and foremost, I thank the Almighty God for how far He has brought me and the strength He has given me through my academic work. I am also grateful to my supervisors, Dr. Augustina Naami and Dr. Efua Mantey Agyire-Tettey. Their comments and suggestions have made this study a success. I ask that God bless them immensely for their hard work and generosity.

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ABSTRACT

Access to quality and timely healthcare is essential to the health and well-being of all individuals with no exception to persons with physical disability. However, people in developing countries tend to have less access to healthcare than those in developed countries, with Ghana not being an exception. The issue of inadequate healthcare services at health facilities and the absence of disability friendly environment have made it difficult for persons with physical disability to access healthcare. However, there is very little information on access to healthcare for persons with physical disability in Ghana. This study explored access to healthcare for persons with physical disability in the Accra Metropolis. The study sought to ascertain the barriers persons with physical disability face in accessing healthcare in the Accra Metropolis, identify strategies persons with physical disability in the Accra Metropolis employed when they were ill and find out participants’ suggestions for improving healthcare services provided by health professionals in the Accra Metropolis. The study adopted a qualitative research design with twenty-one participants purposively sampled from the Ghana Blind Union, Ghana Society for the Physically Disabled and the Ghana National Association for the Deaf. The study found that persons with physical disability in the Accra Metropolis encountered barriers including physical, financial, attitudinal, communication, transportation and inadequate knowledge of health professionals on disability issues in accessing healthcare. The findings also revealed that persons with physical disability resorted to strategies such as hospital care, pharmacy visit, self-medication and exercising faith when they were ill. From the findings, participants suggested that availability of
disability desks and sighted guides at health facilities would help improve healthcare provided by health professionals in the Accra Metropolis. The study concludes that, there is the need to address the issues associated with healthcare for persons with physical disability in order to improve on their overall well-being.
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LIST OF ABBREVIATIONS

ACHPR  –  African Charter on Human and Peoples’ Rights

CRPD    –  Convention on the Rights of Persons with Disability

NHIS    –  National Health Insurance Scheme

OPDs    –  Out Patient Departments

PWDs    –  Persons with Disabilities

UPIAS   –  Union of the Physically Impaired Against Segregation
CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Access to quality and timely healthcare is essential to the health and well-being of all individuals with no exception to persons with disabilities (Beatty, Hagglund, Neri, Dhont, Clark & Hilton, 2003). However, people in developing countries tend to have less access to healthcare than those in developed countries (Peters, Garg, Bloom, Walker, Brieger & Rahman, 2008). But even within these developing countries, the poor have limited access to healthcare due to inadequate financial resources and information (Peters et al., 2008). Furthermore, access to healthcare in Africa manifests it in several aspects including geographical location, accessibility, affordability, availability, and acceptability (O’Donnell, 2007).

Geographical location refers to the setting of health facilities that provide healthcare to people (Bart, Ir, Bigdeli, Annear & Damme, 2011). The closer the geographical setting of health facilities to people, the easier the accessibility of healthcare. According to Bart et al. (2011), accessibility refers to how resources are easily reached at health facilities and these include accessible doors, entrances, ramps, and elevators. Also, lack of available and affordable transportation options and healthcare system barriers, such as ineffective health insurance scheme mostly obstruct individuals’ access to and utilization of healthcare (Marcela Fraizer & Kleinsein, 2009). Affordability of healthcare refers to the cost of healthcare, readiness and capability of the service user to pay for services rendered while available resources, such as a number of health facilities and health professionals, adequate drugs and equipment at health facilities reflect the availability of healthcare (Bart et al., 2011).
In some African countries, quality healthcare delivery is negatively impacted due to lower government budget to finance healthcare, as well as inadequate health insurance coverage (Economist Intelligent Unit, 2017). Furthermore, financial constraints have resulted in the inability of patients to pay for the cost of healthcare provided at health facilities (Atuguba, 2013). Moreover, inadequate health professionals and poor interpersonal skills of health professionals affect access to healthcare (Jacobs, Ir, Bigdeli, Annear, & Damme, 2011). Acceptability of healthcare is the expectation of health service users and the attitudes of healthcare professionals at health facilities (Bart et al., 2011).

Every individual in the world is entitled to quality healthcare (Inclusion Ghana, 2013) irrespective of his or her age, status, educational background, race, disability, gender among other factors (World Health Organization, 2011; Moodley & Ross, 2015). The right to quality healthcare has been enshrined in international and regional human rights treaties such as the African Charter on Human and Peoples’ Rights (ACHPR), as well as other national legislations (Schierenbeck, Johansson, Andersson & Van, 2013) including the 1992 Constitution of the Republic of Ghana which notes that every individual is supposed to enjoy the right to quality healthcare (Inclusion Ghana, 2013). Similarly, the Patient’s Charter of the Ghana Health Service ensures the right of the individual to accessible, fair and comprehensive healthcare without difficulties (Ghana Health Service, n.d.).

In addition, there are international and national laws which protect the right to healthcare for persons with disabilities. These laws include the Convention on the Rights of Persons with Disability (CRPD) and the Persons with Disability Act (715) of Ghana. For instance, Article 25 of the Convention on the Rights of Persons with Disability states that state parties must recognize that persons with disabilities have the right to the enjoyment of the highest attainable
standard of healthcare without discrimination on the basis of their conditions. This is important because, persons with disabilities as compared to those without disabilities have distinctive health needs which result in increased demand for healthcare due to their complex health conditions (Reichard, Stolzle, & Fox, 2011).

Persons with disabilities represent one of the most vulnerable groups (Hwang, Johnston, Tulsky, Dyson-hudson, Wood & Eugene, 2009) and largest minority group in the world (Bella & Dartanto, 2016). Globally, it is estimated that about 650 million people live with some form of disability (United Nations enable, 2017). Also, about 20 percent of the world’s poorest population have a disability and are considered as the most disadvantaged (United Nations enable, 2017). In Ghana, more than 5 million people out of the total population live with some form of disability (Human Rights Watch, 2012). Furthermore, out of the total number of persons with disabilities in Ghana, 25.4 percent have a physical disability (Ghana Statistical Service, 2013).

Disability refers to the limitation of a person’s ability to function or carry out daily activities due to physical, intellectual, sensory or mental impairment (South African Revenue Service, 2012). Disability takes various forms which include sensory, physical, intellectual and cognitive (Government of Western Australia Department of Health, 2014). Physical disability is the most common form of disability and it usually relates to musculoskeletal, circulatory, respiratory and nervous disorders (Government of Western Australia Department of Health, 2014). Physical disability is a common issue in Africa and it continues to increase because of natural disasters, diseases and accidents (Baffoe & Dako-Gyeke, 2013).

Persons with disabilities are one of the marginalized groups in society who encounter challenges in all spheres of life including accessing healthcare (Imoro, 2015). They have difficulties
accessing healthcare due to low income, unemployment and stigmatization (Imoro, 2015) as well as environmental barriers such as inaccessible transport system and infrastructure (Naami, 2014; Tijm, Cornielje, & Edusei, 2011). In Ghana, persons with disabilities encounter barriers in accessing healthcare regardless of both international and local legislations such as the United Nations Convention on the Right of Persons with Disability and the Persons with Disability Act, 2006 (Act 715) of Ghana. The healthcare system in Ghana has failed to address some of the needs of persons with disabilities due to the limited implementation of health policies that specifically address their health issues (Slikker, 2009). Additionally, persons with disabilities in Ghana are underrepresented in the health sector development programs such as the National Health Insurance Scheme (NHIS) (Badu, Agyei-Baffour & Peprah Opoku, 2016). For this reason, the NHIS which covers most ordinary diseases excludes rehabilitation services and assistive devices, as well as covering unique health issues that relate to their disability thereby making its benefit limited for persons with disabilities (Ghana Federation of the Disabled, 2008).

Furthermore, even though the National Health Insurance Scheme (NHIS) was established in 2003 to provide inexpensive and quality basic healthcare, as well as address the inequality in the healthcare system for all residents in Ghana with no exception to persons with disabilities, outcome for persons with disabilities is inadequate (National Health Insurance Authority, 2013; National Health Insurance Act, 2012). This has contributed to the numerous challenges that persons with disabilities encounter in accessing healthcare at health facilities (Inclusion Ghana, 2013; Danso, Ayarkwa & Dansoh, 2011). Moreover, many persons with disabilities have not been able to register onto the NHIS to access healthcare because of financial difficulties and other challenges such as discrimination that they encounter due to their conditions (Mensah, Williams, Atta-Ankomah, & Mjomba, 2008). For this reason, the need to identify and eliminate
the barriers persons with disabilities encounter in accessing healthcare is fundamental in the quest to ensure inclusion and social justice.

1.2 Statement of the Problem

Access to healthcare is a problem for many individuals (Gudlavalleti, John, Allagh, Sagar, Kamalakannan & Ramachandra, 2014). Nevertheless, it could be more serious for persons with disabilities due to the diverse barriers they encounter in society (Mcdoom, Koppelman & Drainoni, 2014). It is estimated that only about 5 percent of persons with disabilities in Ghana have access to healthcare (Badu et al., 2016). Access to healthcare could improve an individual’s general well-being; but persons with disabilities may face diverse barriers in meeting their health needs. Persons with disabilities who cannot afford healthcare at health facilities may be compelled to rely on self-medication (Inclusion Ghana, 2013) or seek services from unqualified practitioners which could impact their health (Hosain, Ganguly, Chatterjee & Atkinson, 2005). When the health needs of individuals are not met, it could result in poorer health status with high rates of mortality, co-morbidities and chronic conditions and this could be worse for persons with physical disability (Inclusion Ghana, 2013). This could increase the burden on caregiving and affect the lives of their families. Again, it could be worse for families caring for those with disabilities due not only to the impairment, but the existence of barriers as discussed earlier. Furthermore, poorer health status could impact on work for everyone but, it could be worse for persons with physical disability as compared to persons without disabilities due to the impairment (Sommers, 2007). This could minimize the human resource capacity of the country and also affect the overall development of the nation.
Studies that have been conducted on access to healthcare for persons with disabilities in Ghana focus mainly on persons with intellectual disability (Inclusion Ghana, 2013) and persons with physical disability in Kumasi (Badu et al., 2016) and Tamale Metropolis (Imoro, 2015) respectively. This study, therefore, sought to explore access to healthcare for persons with physical disability in the Accra Metropolis.

1.3 Objectives of the Study

The general objective of the study is to explore the challenges of and strategies adopted by persons with physical disability in accessing healthcare at health facilities in the Accra Metropolis. The study was conducted with the following specific objectives:

- To ascertain the barriers persons with physical disability face in accessing healthcare in the Accra Metropolis;
- To identify strategies persons with physical disability in the Accra Metropolis employ when they are ill;
- To find out what participants suggest as ways of improving healthcare provided by health professionals in the Accra Metropolis.

1.4 Research Questions

The following research questions guided the conduct of the study:

- What barriers do persons with physical disability face in accessing healthcare in the Accra Metropolis?
• What strategies do persons with physical disability in the Accra Metropolis employ when they are ill?

• What do participants recommend as ways of improving healthcare provided by health professionals in the Accra Metropolis?

1.5 Significance of the study

This research adds to the already existing literature on persons with physical disability and healthcare issues. Also, findings of the study could serve as a guide for scholars who wish to carry out similar studies on access to healthcare for persons with physical disability in other parts of the country and/or the country as a whole. Similarly, the study could provide useful information to the Ghana Health Service and the National Council on Persons with Disability for decision making regarding policies and programs geared towards improving the healthcare for persons with physical disability. The outcome of the study could serve as a guide for social workers and other activists to advocate for the removal of barriers persons with physical disability encounter that prevent them from accessing healthcare. Again, the study outcome could provide medical social workers with vital information to enable them to work more effectively with stakeholders in creating a conducive environment to provide healthcare for persons with physical disability.

1.6 Organization of the study

This study is organized into five chapters. The first chapter of the study includes; background of the study, statement of the problem, objectives of the study and the research questions. The significance of the study and definition of terms have also been captured in this chapter.
chapter two consists of the literature review and the theoretical framework. The chapter three which covers the research methodology has subtitles such as the research design, the sampling technique, sample size, target population, study population, data collection methods, data handling and analysis. The chapter also includes ethical considerations and limitations of the study. In addition, chapter four outlines the findings of the study as well as the discussion of findings. Eventually, the summary of the findings, conclusions, recommendations as well as the implications for social work practice is discussed in chapter five.

1.7 Definition of Terminologies

Access: The ability of people or a population to receive or obtain appropriate healthcare (Marcela Fraizer & Kleinstein, 2009).

Accessibility: Eliminating the barriers to entering and receiving services or working in a healthcare setting (World Health Organization, 2004).

Activity limitations: Difficulties in performing activities (World Health Organization, 2011).

Healthcare: Services provided to individuals or communities by health professionals for the purpose of improving, sustaining, monitoring or restoring health (World Health Organization, 2004).

Impairment: Defect in body function or in body structure (World Health Organization, 2011).
Physical Disability: Injury to muscles, nerves, skin or bones that results in mobility issues or challenges in performing daily activities (Whitehead, 2004).
CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter presents a review of existing literature based on the objectives of the study and theoretical perspective on which the study was carried out. Literature was reviewed under the themes of barriers in accessing healthcare for persons with physical disability, the strategies persons with physical disability employ when they are ill and measures for improvement in healthcare. The Social Model of Disability which is the theory underpinning the study has also been explained.

2.1 Barriers in Accessing Healthcare for Persons with Disabilities

Equality in health requires that all individuals, including persons with disabilities have access to quality healthcare (Elde et al., 2015). However, there is evidence that there are disparities in healthcare provisions (Yee, 2011) in relation to socio-economic status, age, gender, disability, education and ethnicity, which contribute to poor health outcomes and reduce the overall improvement in the quality of healthcare (Krahn, Walker & Correa-De-Araujo, 2015). Persons with disabilities are noted to encounter greater health disparities than those without disabilities (Blick, Franklin, Ellsworth, Havercamp & Kornblau, 2015). Also, there is the likelihood of persons with disabilities to encounter diverse barriers to meeting their healthcare needs (Mcdoom et al., 2014). Barriers such as cost of healthcare (Gudlavalletti et al., 2014), stigmatization (Mccoll, Jarzynowska, & Shortt, 2010) as well as environmental barriers such as inaccessible transport systems and infrastructure (Badu et al., 2016; Gudlavalletti et al., 2014; Naami, 2014; Tijm et., 2011; Aldred & Woodcock, 2008) result in poorer health status of persons with
disabilities (Gudlavalletti et al., 2014).

2.1.1 Physical barriers

A quantitative study conducted by Badu, Agyei-Baffour and Opoku (2016) to examine the barriers to accessing healthcare among persons with physical disability in the Kumasi Metropolis found that persons with physical disability encounter barriers such as inadequate medical equipment, inaccessible door entrance and absence of elevators in accessing healthcare. These findings are similar to an earlier study conducted by Inclusion Ghana (2013) to investigate access to healthcare for persons with intellectual disability in six districts (La Nkwantanang, Accra Metropolitan, Upper Manya Krobo, Kwaebibirem, Ho Municipal and Adaklu) across Greater Accra Region, Eastern Region and Volta Region in Ghana. The findings indicated that physical inaccessibility contributes to challenges persons with intellectual disability face in accessing healthcare at health facilities in Ghana. According to the Centre for Disease Control and Prevention [CDC] (2006), persons with disabilities compared to their non-disabled counterparts encounter problems with architectural designs of health facilities in the United States of America. Similarly, Veltman, Stewart, Tardif and Branigan (2001) argue that in Canada, architectural barriers which include inadequate ramps into health facilities and inaccessible examination furniture obstruct adequate healthcare service provision for persons with disabilities. Then, in Namibia, accessibility to health facilities is a barrier in accessing healthcare for persons with physical disability (Amadhila, 2012).

2.1.2 Communication barriers

Poor communication has been reported in studies as a barrier to accessing healthcare for persons with disabilities in Ghana (Badu et al., 2016; Inclusion Ghana, 2013), United States of America
(Drainoni, Lee-Hood, Tobias, Andrew & Maisels, 2016; Hwang et al., 2009; Scheer, Kroll, Neri & Beatty, 2003) and Namibia (Amadhila, 2012). Hwang et al. (2009) and Scheer et al., (2003) reported that persons with disabilities in the United States of America experience inadequate communication with healthcare providers that usually results in their inability to express their health problems to health professionals. Also, lack of sign language interpreters in health facilities in Ghana (Mprah, 2013) and in South Africa (Hussey, MacLachlan & Miji, 2017) served as one of the reasons why persons with hearing disability could not communicate effectively with health professionals. Consequently, this has led to discomfort for persons with hearing disability because health professionals did not understand them (Mprah, 2013).

It is sad to note from the evidence of the study of Kritzinger, Schneider, Swartz and Braathen’s (2014) that some health professionals in South Africa develop a fear for persons with hearing disability. Therefore, they do not pay attention to the health needs of persons with disabilities, they ignore them by not providing all the information they require, and they also lack confidence in communicating with them. In addition, persons with hearing disability were also reported to have expressed shyness in their encounter with health professionals thereby restricting them from receiving adequate healthcare (Kritzinger et al., 2014). Furthermore, communication barriers make it difficult especially for persons with learning disability to seek help when they are ill (Brown & MacArthur, 2006).

2.1.3 Structural barriers

In 2012, Amadhila reported that despite efforts by the Namibian government to ensure free access to healthcare, persons with disabilities continually face significant barriers in accessing healthcare. Amadhila’s study identified structural barriers which include difficulties and constraints posed by policies and procedures. Drainoni et al. (2006) explained these difficulties
and constraints posed by policies and procedures to involve extensive insurance authorization and procedures as well as frustrations in an attempt to access quality healthcare at health facilities. Furthermore, Scheer et al. (2003) and Drainoni et al. (2006) revealed that structural barriers such as limited health plan benefits at health facilities limits access to healthcare for persons with disabilities in the United States of America. The authors identified structural barriers which involve changes in health insurance policies and procedures such as coverage benefits as a major type of barrier in accessing healthcare for persons with disabilities.

2.1.4 Transportation barriers

Lack of transportation is identified in the available literature as a barrier to healthcare for persons with disabilities in South Africa (Schierenbeck et al., 2013), Namibia (Rooy, Amadhila, Mufune, Swartz, Mannan & Maclachlan, 2012), and United States of America (Scheer et al., 2003). For instance, Rooy et al. (2012) found that in rural Northern Namibia, lack of transportation makes it difficult for persons with mobility disability to walk to health centers for healthcare due to the long distance which impacted on their health. According to Sakellariou and Rotarou (2017), persons with disability in the United Kingdom encounter transportation barriers in accessing healthcare and this usually results in unmet health needs.

Additionally, a study conducted by Hussey et al. (2017) in South Africa revealed that the lack of accessible buses served as a barrier for persons with disabilities to access healthcare or rehabilitation services. Furthermore, the cost of transportation has been identified by Vergunst (2016) as one of the barriers persons with disability in South Africa encounter in accessing healthcare. Similar to this finding is a study conducted by Kleinitz, Nimal, Walji, Mannava and Vicheta (2012) in Cambodia. The findings revealed that, among all the costs incurred in seeking healthcare, transportation cost is increasingly high and this discourages persons with disability
from accessing healthcare. Equally, in rural Namibia, many persons with disabilities experience high cost of transportation, as a result, they walk to health facilities to access healthcare as highlighted by Rooy et al. (2012).

2.1.5 Financial barriers

Studies indicate that financial constraints influence the decision of persons with disabilities to seek healthcare at health facilities (Mccoll et al., 2010; Drainoni et al., 2006). For instance, in Canada the high cost of healthcare hindered persons with disabilities from accessing healthcare at health facilities despite it being funded by government (Mccoll et al., 2010). In the same way, Rooy et al. (2012) have also noted that lack of finance restricts access to healthcare for many rural Namibians with a disability. Moreover, in the United States of America, financial barriers restricted persons with disabilities from accessing healthcare by minimizing their ability to pay for services (Drainoni et al., 2006). In a study conducted by Sommers (2006), the author concluded that persons with disability in the United States not covered by health insurance faced financial difficulties in accessing healthcare and this usually resulted in unmet health needs.

2.1.6 Attitudinal barriers

Attitudinal barriers hinder persons with disabilities from accessing healthcare at health facilities (Maart & Jelsma, 2013). Unfair treatment of health professionals is frequently reported by persons with disabilities who access healthcare at health facilities (Scheer et al., 2003). Furthermore, the kind of attitude and lack of respect for persons with disabilities exhibited by health professionals discourage them from accessing healthcare even though some of them may not have problems with transportation to health facilities (Amadhila, 2012). Similar to Amadhila’s (2012) finding in Namibia, Drainoni et al. (2006) study in the United States of
America which employed a qualitative design found that healthcare providers treated persons with disabilities in a disrespectful manner such as yelling at them and sometimes writing them off when they access healthcare at health facilities.

More so, Vergunst (2016) assessed the negative attitudes of health professionals towards persons with disabilities and also emphasized that in South Africa, persons with disabilities were treated worse at health facilities as compared to those without a disability. Persons with disabilities encounter negative behaviors while interacting with health professionals and are also deprived of healthcare (Vergunst, 2016). As far as the attitudes of health professionals are concerned, a study conducted in Ghana by Mpah (2013) found that negative attitudes of health professionals towards persons with hearing disability compounded communication barriers and this hindered effective interaction.

2.1.7 Inadequate trained health professionals

In addition, Schierenbeck et al. (2013) stipulate that inadequate trained health professionals serve as barriers in accessing healthcare for persons with disabilities in South Africa. These findings are similar to that of Veltman et al., (2001) in Canada which indicate that inadequate knowledge of healthcare providers regarding disability issues has resulted in unmet health needs of persons with physical disability. These findings are consistent with Inclusion Ghana’s report (2013) that lack of training of health professionals in disability issues contributes to challenges persons with intellectual disability face in accessing healthcare at health facilities. These findings are supported by that of Choruma (2007) which specified that inadequate specialized healthcare professionals restrict access to healthcare for persons with disabilities in Zimbabwe and this usually affects their health conditions. Health professionals’ lack of knowledge about disability issues may lead to assumptions and misconceptions about persons with disabilities and these

2.2 Strategies Persons with Disabilities employ when they are ill

The difficulties in accessing healthcare by persons with disabilities and their inability to deal with these problems have led some of them to resort to certain strategies such as self-medication when they are ill (Imoro, 2015). Persons with disabilities in Namibia (Amadhila, 2012) and Vietnam (Palmer, Nguyen, Neeman, Berry, Hull & Harley, 2011) usually cope with the barriers they encounter in accessing healthcare at health facilities by resorting to self-medication. For example, in 2010, Palmer et al. reported that in Vietnam thirty percent of persons with disabilities resorted to pharmacy services when they were ill rather than visiting the health facility to access healthcare from qualified doctors. Some persons with disabilities would rather stay at home when they are ill rather than seek any intervention from a healthcare center.

Moreover, other studies indicate that some persons with disabilities seek the services of unqualified practitioners whenever they are ill. In their study, Hosain et al., (2005) found that a majority of persons with disabilities in rural communities in Bangladesh receive healthcare from unqualified practitioners when they were ill. In the same way, Lishner, Richardson, Levine and Patrick (1996) emphasize that persons with disabilities in rural communities in the United States of America sought healthcare from unqualified physicians due to inadequate health professionals in such communities.

Additionally, persons with disabilities, especially in Africa, consulted traditional healers, herbalists or used herbs when they were ill (Mulumba, Brolan, Ruano, Brooker & Hammonds, 2014). For instance, Amadhila (2012) found that persons with physical disability in Namibia visited traditional healers for treatment rather than the hospital when they were ill. Similarly, in
Uganda persons with disabilities sought help from herbalists when they were ill (Mulumba et al., 2014). Furthermore, in some African countries, persons with disabilities in rural communities rely extensively on herbal medicines due to the challenges they encounter in accessing healthcare at health facilities (Imoro, 2015).

Persson and Ryden (2006) assert that self-trust is another strategy adopted by persons with disabilities in Sweden when they were ill. They described the phenomenon as having the ability to manage stressful situations. They further explained that having a social trust which is support from friends and family relations, and denial (refusal to accept a painful situation) are approaches to effective management of health conditions (Persson & Ryden, 2006). With regards to denial, persons with disabilities negate the seriousness of their illnesses by avoiding the implications of their conditions (Jones & Barlette, n.d.). Moreover, other persons with disabilities used engagement strategies which include seeking social support and engaging in goal-oriented activities such as problem-solving and planning in place of accessing healthcare when they were ill (Livneh & Antonak, 2005). Seeking social support enables persons with disabilities to better adjust to psychological distress when they are ill (Pakenham, 1999).

On the other hand, some persons with disabilities used disengagement strategies when they were ill to relieve them of pain (Livneh & Antonak, 2005). Disengagement strategies include the wish to fulfilling desires such as blaming one’s self (Gadsby & Jones, 2014) and the abuse of substance such as alcohol and drugs (Livneh & Antonak, 2005; Belguzar & Cengiz, 2011). Likewise, a qualitative study conducted in Eastern Canada revealed that alcohol and drug usage enables persons with disabilities to cope with illnesses (Hutchinson, Loy, Kleiber & Dattilo, 2003). Also, relaxation was identified as a useful approach for persons with disabilities in Canada adopted when they were ill (Hutchinson et al. 2003). Consequently, to reduce the pain
associated with some of the illnesses, Carr and Owen-DeSchryver (2006) assert that persons with developmental disabilities in the United States of America use heating pads, bed rest and dietary change.

### 2.3 Measures to improve healthcare

According to Inclusion Ghana (2013), to improve on healthcare for persons with intellectual disability in Ghana, the Ghana Health Service should ensure appropriate medications are covered under the National Health Insurance Scheme. Also, educating health professionals on disability issues and how to provide healthcare is very vital in improving healthcare for persons with disabilities (Sharby, Martire & Iversen, 2015; Neri & Kroll, 2003). In a study by Melville et al. (2005) on enhancing primary healthcare for adults with intellectual disability in the United Kingdom, the authors revealed that enhancing training of health professionals is a key component in improving healthcare and addressing health disparities experienced by people with intellectual disability. Similarly, Ganle, Otupiri, Obeng, Edusie, Ankomah & Adanu (2016) conducted a qualitative study in Ghana and found that a way of improving healthcare provided by health professionals to persons with disabilities is to educate them on disability issues.

Likewise, Ali, Scior, Ratti, Strydom, King and Hassiotis (2013) emphasized that improving healthcare for persons with intellectual disability in the United Kingdom requires training of health professionals on their needs. According to the World Health Organization, education and training programs for health professionals should include relevant information on disability to improve healthcare for persons with disabilities. Furthermore, the knowledge of health professionals on disability issues can be enhanced and the services they provide can be improved when persons with disabilities play the role of educators (World Health Organization, 2011).
2006, Brown and MacArthur asserted that the availability of special equipment and aids are vital approaches to improving healthcare for persons with learning disability in the United Kingdom. In a similar vein, Badu et al. (2016) affirmed that in Ghana, improvement in healthcare for persons with a physical disability will require regular assessment of medical equipment to ensure their accessibility. Also, health facilities should take the health needs of persons with disabilities into consideration when procuring medical equipment (Badu et al., 2016).

A way of improving healthcare for persons with disabilities in Ghana includes reviewing existing policies and programs (Badu et al., 2016). In addition, Badu et al. (2016) suggested that existing regulations and policies for construction and redesigning health facilities in Ghana should be reviewed by the Ministry of Health to ensure that health facilities are disability-friendly to improve healthcare for persons with disabilities. To reinforce the above submission made by Badu et al. (2016), Imoro (2015) suggested that government should improve the architectural design of health facilities to enable persons with physical disability to have access to healthcare. Besides, the World Health Organization (2011) opined that changes in laws and review of policies are suitable for providing health needs and improving healthcare for persons with disabilities. Furthermore, making all levels of healthcare systems and public healthcare programs more inclusive and accessible will improve healthcare for persons with disabilities (World Health Organization, 2011).

Additionally, Amadhila (2012) proposed availability of mobile clinics in villages as a way of improving healthcare for the physically impaired population in Namibia. In the same way, Inclusion Ghana (2013) recommended that the provision of mobile health vans especially in rural areas in Ghana will improve healthcare for persons with intellectual disability. In the same vein, Ganle et al. (2016) asserted that provision of free or subsidized disability friendly transport
services to and from health facilities would improve the healthcare of persons with disabilities in 
Ghana. Furthermore, effective communication and the use of appropriate communication tools 
such as discussions and seminars between persons with disabilities and health professionals are 
essential in improving healthcare (Sharby et al., 2015; Brown, MacArthur & Mckechanie, 2010). 
These are all suggestions made by researchers. It is imperative to document recommendations of 
persons with disabilities themselves about ways to improve their healthcare since they are the 
experts of their conditions and understand it much better than anyone else.

2.4 Theoretical Framework

The Social Model of Disability formed the theoretical basis of the study. The Model was 
proposed by advocates of the Union of the Physically Impaired Against Segregation (UPIAS) in 
1976 (Shakespeare & Watson, 2002). The Model was given academic integrity through the 
(Shakespeare & Watson, 2002). The Social Model of Disability developed from the fundamental 
principles of disability postulates that persons with disabilities are not disabled by their 
disabilities but by the disabling challenges they encounter in society (Union of the Physically 
Impaired Against Segregation, 1976). The Social Model of Disability views persons with 
disabilities as an oppressed group in society (Shakespeare & Watson, 2002). The Model further 
reveals that it is not the disability of the individual that is disabling, rather, factors such as; 
societal structures, values, culture, environmental constructs (Geffen, 2013), inadequate access to 
healthcare, unemployment, transportation barriers and inaccessible buildings affect the lives of 
persons with disabilities (Barnes & Mercer, 2005).
The theory emphasizes that, inadequate policies, programs and the exemption of persons with disabilities from their implementation result in barriers which include institutional (Scullion, 2010). The institutional barriers comprise laws, policies, and practices that discriminate against persons with disabilities (Barnes and Mercer, 2005). The Model accentuates on the inclusion of persons with disabilities in mainstream society through the identification and elimination of barriers such as attitudinal, architectural, transportation and information (Shakespeare & Watson, 2002).

2.4.1 Usefulness of the Social Model of Disability to the Study

The Social Model of Disability was useful to the study in diverse ways. The theory facilitated the researcher’s understanding of barriers (architectural, transportation, attitudinal and institutional barriers) that persons with physical disability in the Accra Metropolis encounter in accessing healthcare and the effects of the barriers. Furthermore, the theory helped in the analysis of data as well as making appropriate recommendations for policy and practice decisions that could help address the barriers persons with physical disability face in accessing healthcare at health facilities.
CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

This chapter gives details of the research methods used to obtain data for the study. The chapter provides information on the research design, study area, target population, study population, sampling technique, sample size, sources of data, methods of data collection, data handling and analysis, credibility and trustworthiness of the study and ethical considerations.

3.1 Research Design

The study employed a qualitative research design with a phenomenological approach. The qualitative design is a design which helps researchers to achieve deep and holistic idea about the context being studied, frequently concerning interacting within the daily lives of individuals, groups, communities, and organizations (Gray, 2004). Phenomenological approach is a qualitative research tradition that clarifies the specific, identifies phenomena through how they are professed by the actors in a condition (Lester, 1999). Thus, phenomenological approach helped the researcher to clarify study participants’ understanding on the challenges they encounter and the strategies they adopt in accessing healthcare in the Accra Metropolis from their own experiences. Qualitative design helped the researcher to gain an in-depth understanding about access to healthcare from the participants’ point of view (Creswell, 2013). Therefore, this study adopted a qualitative design to gain insight into access to healthcare for persons with physical disability in the Accra Metropolis.
3.2 Study Site

The study was carried out in the Accra Metropolis in the Greater Accra Region of Ghana. The Accra Metropolis is among the twenty-six metropolitan, municipal and district assemblies in the Greater Accra Region (Ghana Districts, n.d.). The Accra Metropolis has been the regional capital for the Greater Accra Region since its establishment in 1898 (Ghana Statistical Service, 2014). The Accra Metropolis is surrounded by Ga West Municipal to the North, Ga South Municipal to the West, Gulf of Guinea to the South, and to the East by La Dadekotopon Municipal. The total land area of the Metropolis is 139.674 Km2 (Ghana Statistical Service, 2014).

The total population of the Metropolis is 1,665,086 (that is, 800,935 males and 864,151 females) and about 2.8 percent of the total number has a form of disability or the other (Ghana Statistical Service, 2014). According to the Accra Metropolitan District Analytic Report of the 2010 Population and Housing Census, 47,281 people out of the total number of people in the Metropolis live with some form of disability (Ghana Statistical Service, 2014). The percentage of males with a disability is slightly lower (47.5%) than females (52.5%) in the Accra Metropolis (Ghana Statistical Service, 2014). Besides, the forms of disability in the Metropolis include speech, physical, sight, hearing among others. The Accra Metropolis has the majority of its population occupied with occupations, such as farming, construction, fishing, trading, manufacturing, provision of services among others (Ghana Statistical Service, 2014).

Accra Metropolis was selected as the study site because it is the metropolitan area with the highest number (47,281) of persons living with disabilities as compared to Ga South (8,143), Ga West (5,452), Dangme West (2,834) among other districts in the Greater Accra Region (Ghana Statistical Service, 2014). The Metropolis is entirely urban and a cosmopolitan area with
inhabitants from diverse social and cultural backgrounds. Moreover, the Metropolis is a lively setting made up of many public and private institutions as well as different groups of people including persons with physical disability. In addition, there are many healthcare facilities in the Accra Metropolis as compared to other metropolitan areas in Ghana. Due to these characteristics, the researcher was motivated to choose this area as the study site.

3.3 Target Population

The study targeted all persons with disabilities in the Accra Metropolis. The target population for a study refers to the whole set of units for which the study data is to be used to make conjectures (Lavrakas, 2008).

3.4 Study Population

Study population refers to a part of the population that is studied (Nworgu, 1991). The study population was persons with physical disability specifically: visual, hearing and mobility disabilities who accessed healthcare in the Accra Metropolis.

3.5 Sampling Technique

Sampling refers to the process whereby a researcher selects a specific subset of a population to make inference about the nature of the total population (Marshall & Rossman, 2014). Purposive sampling technique was used to select persons with physical disability for the study. The technique involves a situation whereby participants are deliberately selected for a study due to their qualities (Russell, 2002). This technique was employed to attain a thorough data from participants who were experienced in issues related to access to healthcare. This sampling technique further helped the researcher to select participants who provided the desired
information for the study. Furthermore, the technique enabled the researcher to collect data from study participants who met the criteria for selecting participants for the study.

To recruit participants, the researcher contacted officials of the Ghana Blind Union, Ghana National Association for the Deaf and Ghana Society for the Physically Disabled who were gatekeepers to persons with visual, hearing and mobility disabilities respectively. The contact information of the persons with physical disability was obtained from the gatekeepers. The study participants were contacted through phone calls and text messages. The researcher explained the purpose of the study to them and those who showed interest in the study were recruited for the study.

3.5.1 Inclusion Criteria

Persons who had either visual, hearing or mobility disability and were also members of the Organizations for Persons with Disabilities were selected for the study. Furthermore, all the participants should be within the working age group in Ghana. According to the National Analytical Report of the 2010 Population and Housing Census, the potential working age group in Ghana is between fifteen to sixty-four years (Ghana Statistical Service, 2013). Hence, participants in this study were between the ages of fifteen to sixty-four years. Additionally, the study participants employed for this study must have accessed healthcare at health facilities in the Accra Metropolis.

3.6 Sample Size

The study recruited twenty-one participants, including eleven males and ten females. Twenty-one participants were recruited because according to Creswell (1998), the sample size for a qualitative study should range from five to twenty-five participants to reach saturation. Out of
the twenty-one participants were seven each of persons with visual, hearing and mobility
disabilities. Twenty-one participants were selected because the number was manageable within
the time frame, it helped to achieve different views, to gather rich data, and at this point,
saturation had been attained.

3.7 Source of Data

The data for the study was based on primary source. Primary data was collected from
participants through in-depth interviews. In-depth interviews enabled research participants to
express themselves freely on the phenomenon under study.

3.8 Methods of Data Collection

An interview was scheduled with the research participants. Data were collected from participants
through in-depth interviews with the aid of an interview guide. The interview guide was designed
in English language based on the research objective. However, interviews were conducted by the
researcher in English, Twi and Ga. This was because these were the languages study participants
understood. In addition, interviews were conducted in sign language for persons with hearing
disability. A sign language interpreter was employed to assist in data collection for participants
with hearing disability. Furthermore, the interviews took place at the agreed locations and time
by the participants and researcher and lasted approximately forty to sixty minutes. With
permission from participants interviews were audio recorded.

3.9 Data Handling and Analysis

The audio recorded data obtained from interviews with participants were safely stored on the
researcher’s computer. The files were protected with a password to avoid access by unauthorized
persons. The recorded data from interviews with participants were transcribed from the audio into text for analysis. The transcribed data were analyzed using Braun and Clarke (2006) six steps of thematic analysis of qualitative data. I read through the transcribed data repeatedly for familiarization. This helped me to develop meanings and ideas into the data. I generated Phrases that were similar and based on this, themes were developed. I reviewed the themes to obtain the main and sub-themes after which they were clearly defined and named. Furthermore, I produced findings based on the themes created and supported my findings with the voices of the participants.

3.10 Credibility and Trustworthiness of the Study

In ensuring the credibility and trustworthiness of the study, peer debriefing was employed. Peer debriefing allows a panel of experts or colleagues in the field to reanalyze the data (Rolfe, 2016). Based on this method, the credibility of the study was ensured by allowing supervisors to review the research process and findings of the study.

3.11 Ethical Considerations

To observe the ethics of research, voluntary participation, informed consent, confidentiality, and plagiarism were adhered to. To ensure voluntary participation, participants were informed that their involvement in the study is of their own free will and they can withdraw from the study at any point. This was done after the purpose of the study had been clearly explained to them. Furthermore, the consent of participants was sought by requesting them to append their signatures on consent forms after the purpose of the study had been explained and understood by them. However, participants who could not sign were requested to thumbprint. The actual names of participants were replaced with pseudonyms to ensure confidentiality. Finally, all works used in this study have been duly acknowledged.
3.12 Limitations of the Study

Data loss may have occurred when the sign language interpreter was construing messages to the participants with hearing disability. This is because the researcher was not directly engaged with persons with hearing disability due to her inability to sign. Furthermore, relevant information may have been lost when data was translated from the local languages to English. Hence, similar words were used to replace words whose actual meaning could not be obtained.
CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents the findings of the study and discussions. The findings are presented on themes: demographic characteristics of study participants, strategies persons with physical disability in the Accra Metropolis employed when they were ill, the barriers they faced in accessing healthcare at health facilities and their recommendations to improve on their health situation. The chapter also discusses the findings of the study.

4.1 Demographic Characteristics of Participants

This section presents the demographic information of study participants. The analysis captures the forms of disability, the age of participants, educational level of the participants, religious affiliation, marital status, employment status, number of children and disability status of participants.

4.1.1 Various Forms of Disability

Table 1: Forms of Disability

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Number of People</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Visual</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Hearing</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Mobility</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data
Table 1 shows a summary of the various forms of disability as well as the sex of study participants. Twenty-one (21) persons with physical disability made up of seven each of persons with visual, hearing and mobility disabilities participated in this study. The study participants comprised of eleven males and ten females.

4.1.2 Age of Participants

Table 2: Age Range of Participants

<table>
<thead>
<tr>
<th>Age Range</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Participants</td>
<td>7</td>
<td>3</td>
<td>9</td>
<td>2</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Field Data

From Table 2, nine (9) study participants were between the ages of 41-50 and seven (7) were between 21-30 years. Also, three (3) participants were between the ages of 31-40 while two (2) were between 51-60 years.

4.1.3 Level of Education

Table 3: Participants’ Level of Education

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Elementary</th>
<th>JHS</th>
<th>SHS</th>
<th>Technical/Vocational</th>
<th>Tertiary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>7</strong></td>
<td><strong>3</strong></td>
<td><strong>2</strong></td>
<td><strong>6</strong></td>
<td><strong>21</strong></td>
</tr>
<tr>
<td>Males</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data
As shown in Table 3, the majority of the participants had attained Junior High (7) and tertiary education (6) with three (3) of them having elementary education. Three (3) participants also attained Senior High education and two (2) had technical/vocational training.

4.1.4 Religious Affiliations of Participants

Table 4: Religious Affiliations of Participants

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Christian</th>
<th>Muslim</th>
<th>Traditional</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>1</strong></td>
<td><strong>-</strong></td>
<td><strong>1</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Christian</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>9</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>10</td>
<td>-</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data

Table 4 provides information on the religious affiliation of study participants. It is evident in the table that the majority of the study participants (19) were Christians while two (2) persons with visual disability were Muslim and Rastafarian respectively.
4.1.5 Marital Status

Table 5: Marital Status of Participants

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Single</th>
<th>Cohabitating</th>
<th>Married</th>
<th>Separated</th>
<th>Divorced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>21</strong></td>
</tr>
<tr>
<td>Males</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>9</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data

As shown in table 5, among the study participants thirteen (13) were single, three (3) were married, two (2) cohabitating and two (2) divorced. One (1) was separated.

4.1.6 Employment Status

Table 6: Employment Status of Study Participants

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Formal Sector</th>
<th>Informal Sector</th>
<th>Unemployed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>4</td>
<td>-</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>5</strong></td>
<td><strong>10</strong></td>
<td><strong>21</strong></td>
</tr>
<tr>
<td>Males</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data
The employment status of study participants is illustrated in table 6. As shown in table 6, about half of the participants (10) were unemployed. They comprised four (4) persons with hearing disability and three (3) each of persons with visual and mobility disabilities. Six (6) participants were working in the formal sector and five (5) in the informal sector.

4.1.7 Number of Children

Table 7: Number of Participants’ Children

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>No Child</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

Source: Field Data

As shown in Table 7, the majority of the participants (11) had children while the remaining (10) had no children. Among the study participants with children, persons with mobility disability had the highest number (5) followed by persons with visual disability having four (4) children with persons with hearing disability recording the lowest number of children (2).
4.1.8 Period Condition was Acquired

Table 8: Period Participants Acquired their Condition

<table>
<thead>
<tr>
<th>Forms of Disability</th>
<th>Congenital</th>
<th>Childhood</th>
<th>Adulthood</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>-</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Hearing</td>
<td>3</td>
<td>4</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Mobility</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>15</strong></td>
<td><strong>3</strong></td>
<td><strong>21</strong></td>
</tr>
<tr>
<td>Males</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>2</td>
<td>8</td>
<td>-</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Field Data

Three (3) of the participants with hearing disability acquired their condition from birth. Fifteen (15) participants have lived with their condition since childhood. The remaining participants had their condition in their adulthood (See table 8).

4.2 Objective One: Barriers in Accessing Healthcare by Persons with Physical Disability

The first objective was to ascertain the barriers persons with physical disability face in accessing healthcare in the Accra Metropolis. Findings under this objective have been categorized under the following themes: physical barriers, communication barriers, transportation barriers, financial barriers, attitudinal barriers and inadequate knowledge of health professionals on disability issues.

4.2.1 Physical Barriers

Under the theme physical barriers, sub-themes which emerged include: access to entrances; access to inside arrangement of doctors’ offices, admission wards and Out Patients Departments
(OPDs); lack of and access to furniture and hospital equipment.

**Access to Entrances**

The study found that entrances to hospitals, doctors’ consulting rooms, laboratories, Out-Patient Departments (OPDs), pharmacies, records department as well as washrooms and the general hospital environment were not accessible for participants, especially those with mobility disability. The inaccessibility of entrances at hospitals was due to basic elements of the buildings such as inaccessible stairways, unusable ramps which are mostly steep and narrow. In addition, heavy doors, narrow doors, and high doorknobs caused inaccessibility to entrances. Persons with mobility disability reported that they had difficulty entering hospital buildings because there were stairways with no ramps. One of the participants expressed her sentiments thus:

*So far my challenge at the hospital is the staircase. Even though I use crutches, I find it difficult climbing the staircase to go places. When I go to the hospital, I also watch those in wheelchairs and I realize that those pushing them at the back find it difficult to lift them on the staircase* (Participant 16, a female crutches user).

Another participant also had this complaint:

*There are stairs at the hospitals which I cannot climb. The stairs do not have ramps attached. If I want to climb the stairs and go somewhere, then it means I have to look for someone to assist me by adjusting my wheelchair. It is very difficult for me* (Participant 10, a male wheelchair user).

As a result of the inaccessible stairways, some of the participants noted that they had to stand outside to receive treatment from doctors and this puts their privacy at stake as their personal information are disclosed in the open.
The hospital I go to has stairs in front of its doors which I am unable to climb so I always use the back door. Even with the back door, I cannot go in with my wheelchair so I have to stand outside for the doctor to come and attend to me. I do not have my privacy because whatever I have to tell him, I need to say it in the open. I am not happy about this (Participant 4, a female wheelchair user).

Furthermore, while some hospitals lacked ramps, others had rough and highly raised ramps which hindered access to health facilities. These are what some participants said:

The hospitals I visit have no ramps and this applies to the one closer to the Accra Rehabilitation Centre. That hospital is not accessible at all, no ramp (Participant 3, a male wheelchair user).

Though there are few ramps at 37 Military Hospital, they are very high and rough. There is no ramp at the entrance of the laboratory rooms so I have to use the stairs and it is very difficult. When I was pregnant, the issue of ramp and laboratory test was very difficult for me. I usually pleaded with the people to assist me (Participant 20, a female crutch user).

While some places at the hospital have ramps, others do not. Ramps in most of the hospitals I visit are very high and not easily accessible. There is a ramp at the entrance of one of the hospitals I usually visit, but where I pass to the doctor’s office has no ramp. I always have to wait for someone to lift me up in my wheelchair before I can get to the doctor’s office. Assuming you are in pain and need to see the doctor urgently, it means you have to wait for someone to assist you before you can get in. It makes me feel like we persons with mobility disability are not part of the people in the country. They don’t take us into consideration (Participant 4, a female wheelchair user).

Additionally, a number of participants with mobility disability reported that the entrances to doctors’ offices or consulting rooms were narrow and they had difficulty getting in with their wheelchairs. Below are examples of some participants’ experiences with this phenomenon:

In the doctor’s office, I usually use my wheelchair, but the problem is with the
entrance to the doctor’s office. It is narrow. I have difficulty going in with my wheelchair. Whenever I want to talk about this issue the majority of the doctors disagree with me. They make it looks like you should keep quiet and not complain about their office (Participant 3, a male wheelchair user).

One of the challenges I have at the hospital is the entrances to some of the doctors’ consulting rooms. They are very narrow. I suffer before I am able to go inside (Participant 10, a male wheelchair user).

From the study findings, inaccessible entrances to records department was also a challenge for persons with mobility disability especially wheelchair users. This is because the entrances of some records department were narrow and they had difficulty getting in. In addition, records department counters posed as a barrier to wheelchair users. They stated that because the counters were highly raised, they were unable to see the attendants to communicate effectively. See below narratives of two participants:

The entrance of the records department is narrow and the counter where we take our folders is not accessible. You have to raise your neck and stretch before you can see the one behind the counter and talk to him or her. When they don’t see you then, they begin to scream, “Where are you? Where are you?” They have to do something about the counter because it is a barrier (Participant 3, a male wheelchair user).

Because I am in a wheelchair, the entrance and counter at the records department are not accessible for me. It is too high. I have to call the nurses behind the counter to come outside and attend to me because I can’t see them (Participant 4, a female wheelchair user).

Not only were some hospital doors narrow, but they were also heavy with high knobs that restricted some persons with physical disability from opening those doors. One of the study participants lamented his inability to access a door:
Some of the door knobs are very high and I have to stretch my hand to reach it whenever I am in a wheelchair. At times, I plead with people to open the door for me. Some of the hospital doors are also heavy and narrow. These make it very difficult for me to enter the hospital (Participant 10, a male wheelchair user).

Besides, some participants with mobility disability emphasized that laboratory doors in hospitals they visited hindered access. As a result, some of them indicated that they usually received services outside of the laboratories. They expressed their sentiments thus:

*I am unable to pass through the laboratory door at the hospital I go because it is narrow, so I usually stand outside for the laboratory technician to take my blood sample for a test* (Participant 4, a female wheelchair user).

*All doors at the hospitals I have visited, including that of the laboratory room are not accessible at all. They are all narrow* (Participant 3, a male wheelchair user).

Some participants with mobility disability also stated that entrances to pharmacy shops they visited were narrow, which hindered wheelchair access. Hence services were received outside of the shop.

*I am unable to go to the pharmacy because the entrance is narrow. I always have to stand outside for the pharmacist to come and attend to me there. I feel uncomfortable about this arrangement. I really want to go in there, but I am unable to do so because my wheelchair cannot pass through the entrance* (Participant 10, a male wheelchair user).

Further, some participants with mobility disability asserted that entrances of pharmacy shops they visited were not accessible because of the presence of a highly raised pavement in front of the shop; as a result, healthcare was rendered to them outside of the shop.

*The pharmacy I buy medicines from is not accessible at all. I have to wait outside for the pharmacist to come and attend to me because the edge of the pavement is too high for me to climb* (Participant 4, a female wheelchair user).
Interestingly, while some participants with mobility disability received services in front of pharmacy shops due to the inaccessibility of their entrances, others requested the help of pharmacists to enter the shops.

*When I get to the pharmacy, because there is no ramp, the place is not accessible. I always plead with the pharmacists to help me* (Participant 20, a female crutches user).

The study found that entrances to washrooms in some hospitals were not accessible for persons with mobility disability, especially wheelchair users as they mentioned that the entrances were not only narrow but also had stairs in front of them which made the place inaccessible. This scenario is described below by few participants:

*With the washroom, the place is not good at all. A hospital I visited two months ago had stairs at the entrance of its washroom. My wheelchair could not pass through the entrance because it was narrow so I got down and crawled to the washroom* (Participant 4, a female wheelchair user).

*It is very difficult for me to use the washroom at the hospital. You can’t use the washroom if you don’t have anyone to assist you because the entrance is narrow. There are stairs at the entrance of the washroom and I cannot go in with my wheelchair* (Participant 10, a male wheelchair user).

It is worthy to note that study participants who managed to enter inaccessible washrooms said that they found it difficult to use the place due to slippery floors. The following narratives were given by such participants:

*The washroom at a hospital I visited was a more bit accessible, I managed to get in. However, the floor is smooth and if you are not careful, you can easily fall into someone’s urine* (Participant 20, a female crutches user).
The washrooms are not friendly at all. The floors are slippery too, and you can fall easily. If I go there without an aid, I really suffer. I sometimes step in urine (Participant 12, a male with visual disability).

Access to inside arrangement of doctors’ offices, admission wards, OPDs and pharmacies

The study also found that poor arrangement of examination chairs in doctors’ offices and Out-Patient Departments (OPDs) restricted the movements of participants with mobility disability due to limited turn-around space. This scenario has been described below:

The arrangement of chairs in the doctor’s office and OPD restricts my movement. I have to sit closer to the doctor, but because the arrangement is bad in the office, I am unable to do so. At times when they see you enter the office is when they start rearranging things to enable you to use your wheelchair (Participant 3, a male wheelchair user).

Similarly, inadequate turn-around space at the Out-Patient Departments restricted the movements of persons with mobility disability in hospitals. Some study participants gave these complaints:

At the OPD, how you will sit is a challenge. You have to be moving from one seat to the other and it is not easy at all. I cannot move about freely at the OPD. The place is not spacious. It is not easy (Participant 20, a female crutches user).

Hmm, at the OPD the place is not well designed. There is not enough space to ride your wheelchair because of the poor arrangement of chairs. Because the place is not spacious, I ride my wheelchair in one direction and I am very careful (Participant 3, a male wheelchair user).

Inadequate turn-around space was also identified at the admission wards as physical access barriers for persons with mobility disability due to inadequate spaces which restricted their movements. A participant expressed her frustration:

The admission ward at the hospital I visit is not spacious enough. I remember when I was on admission some time ago, I couldn’t park my wheelchair in the
ward because the place was not spacious enough so it was parked outside. I had to call someone to bring my wheelchair to me when I wanted to go out if I do not get anyone; I cannot go out (Participant 4, a female wheelchair user).

Additionally, it was indicated by a few study participants that the floors of admission wards were slippery because they were tiled. Some participants with mobility and visual disabilities stated that they risked falling while walking on these slippery floors. The narratives of participants four and seven are examples of this situation:

*The floor tiles of the admission ward at the hospital I visit are very slippery. This makes the place inaccessible. I am always scared to fall* (Participant 4, a female wheelchair user).

*The floors of admission wards of a hospital I visited had been tiled with smooth tiles which were very slippery and dangerous. You can easily fall and hurt yourself* (Participant 7, a male with visual disability).

Again, inside of pharmacy shops presented challenges to some study participants, especially wheelchair users as they could not access the counters. Some participants with mobility disability, particularly, wheelchair users mentioned that because the counters at the pharmacy shops were high, they could not be seen behind the counters by attendants. Hence, they were delayed in receiving healthcare and other persons without disability go past them to be attended to.

*The counters at the pharmacies of the various hospitals I visit are not disability friendly, they are very high. Due to this, I usually delay in a queue before I am served. Because the pharmacist behind the counter cannot see me she is unable to attend to me. This makes other service seekers, mostly those without a disability pass by me in the queue* (Participant 4, a female wheelchair user).
**Lack of and Access to Furniture and Hospital Equipment**

Other physical barriers mentioned by participants were inaccessible furniture which includes: beds, laboratory chairs, examination tables and chairs and lack of medical equipment such as height rod and weighing scale in hospitals. With respect to furniture, the study findings show that beds in the admission wards were high such that some participants were not able to climb. Hence, they slept on the floor while they were on admission. This is described below.

*I was admitted at the hospital one day and because the bed was not accessible, I had to sleep on the floor. I was in a coma then, and I did not know what was going on. As soon as I regained consciousness, I asked why I was on the floor and I was told it is because I could not climb the bed and therefore they had to put me on the floor* (Participant 3, a male wheelchair user).

It must be emphasized that women with mobility disability faced accessibility challenges with beds in the scan rooms and labor wards of the hospitals they visited. One of such participants indicated that:

*The beds at where they take the scan are very high just like the ones used by persons without disabilities. I sometimes have to hold the bed before I can climb. The beds are not accessible at all. With the labor ward, where I delivered the first time, the bed was high. Just imagine a woman who is in labor being asked to climb a bed and you are not lifted up by someone, but you have to get on the bed yourself. So when I tried and I was able to climb the bed, my leg hit a bucket filled with waste substances. If the bed was accessible, I don’t think my leg would have hit the bucket* (Participant 4, a female wheelchair user).

The findings of the study indicate that examination tables and chairs used in doctors’ offices and laboratory rooms were high and not suitable for persons with mobility disability. A number of study participants with mobility disability emphasized that they were assisted to use the tables and chairs. In addition, few persons with visual disability had challenges with examination chairs
in consulting rooms at health facilities. Some of them stated that the chairs in consulting rooms were unstable and made them feel uneasy. Few participants described their ordeal as noted below:

*The examination tables and chairs in the doctors’ offices are not accessible. They are normal for everybody, but not persons with disability. The nurses helped me climb the examination table in the doctor’s office the other day when I visited the hospital because it was high* (Participant 20, a female crutches user).

*To me, the laboratory chairs are not accessible; I know they are there for those without disabilities and not us. The chairs are of the same height* (Participant 4, a female wheelchair user).

*Some time ago, I almost fell because of the chair in the doctor’s office. It wasn’t stable. It was this kind of chair that turns around. Some of the chairs make me feel uncomfortable* (Participant 19, a female with visual disability).

Lack of accessible weighing scales and height rods were also identified as impediment for persons with mobility disability in accessing healthcare. Participants, specifically, wheelchair users who took part in the study stated that they did not know their weight and height measurements because of the unavailability of these equipment. A male wheelchair user made this comment:

*Persons with mobility disability are unable to check their weight. This is because we don’t have that machine in Ghana. I have visited lots of hospitals in the Accra Metropolis so I know what I am talking about. No scale in hospitals in Ghana can check our weight. I also don’t know my height because the machine used in checking is not accessible at all, and this is a very big issue* (Participant 3, a male wheelchair user).

### 4.2.2 Financial Barriers

The majority of persons with physical disability who participated in this study pointed out that
they had difficulty paying hospital bills. The National Health Insurance Scheme (NHIS) which is supposed to help reduce their burden of healthcare did not cover all their hospital expenses. Some of the participants made these statements to confirm the fact that they had financial constraints:

*I have the health insurance, but it does not cover everything. I remember the last time I went to the hospital it didn’t cover anything. I used my own money to pay for my hospital expenses. Sometimes, I do not have enough money so I had to use my money meant for food to buy the drug. The medicines are very expensive and at times I ended up paying for some of the medicines and leaving others* (Participant 19, a female with visual disability).

*When I go to the hospital, I pay bills myself even though I have health insurance. Sometimes, when I cannot pay for the medicines the insurance does not cover. I go back to the doctor and lobby for similar medicines which are affordable* (Participant 20, a female crutches user).

Due to the financial constraints, some participants did not access healthcare at the hospital since they did not want to go through any humiliation of not being able to pay for their bills. One of the participants who found himself in such a situation said that:

*If I am sick, I do not go to the hospital because I do not have the means and do not want to be embarrassed because there is no money* (Participant 3, a male wheelchair user).

Some of the participants also said that they had difficulties buying prescribed medicines because they did not have money. For example, one female participant made this pathetic comment:

*When the prices of prescribed medicines are high at times, I do not buy them at all because I do not have the money. I put the prescription form in my bag and go home* (Participant 20, a female crutches user).

Other participants claimed they did not have enough money to buy medicines at the pharmacy
because the medicines were expensive. Study participants in such circumstance sadly said:

_The medicines at the pharmacy are expensive. If I have the money I buy if not, I don’t buy at all_ (Participant 7, a male with visual disability).

_The challenge I have is that the medicines doctors ask me to buy are expensive. Because I don’t have money to buy at times I have to call the doctor and inform him about the high cost of the medicines_ (Participant 14, a woman with hearing disability).

_Going to the pharmacy is all about money. Sometimes when the prices of medicines are high, I don’t buy the medicines at all because I do not have the money_ (Participant 20, a female crutches user).

However, few participants who were gainfully employed acknowledged that they had no issues paying their hospital bills.

_I pay for my hospital bills myself. I am a trader so when I fall sick, I do sell some of my products and I get money to pay for my bills_ (Participant 1, a female with hearing disability).

_I pay my own hospital expenses without anybody’s assistance. I do not have any challenge in paying for my hospital bills because I am working_ (Participant 5, a male with visual disability).

Furthermore, some participants added that they received financial support from family members and friends to enable them to access healthcare. This is evident in these statements by a number of participants.

_I use the national health insurance. But services that are not covered by the health insurance I pay myself with the assistance of my parents_ (Participant 15, a female with hearing disability).
Sometimes I use my own pocket money to pay for my medical expenses. I must say that about ninety percent of my medical expenses are paid by my friends. They have been very helpful (Participant 11, a male with visual disability).

Additionally, a participant with hearing disability confirmed that he received support from the District Assembly Common Fund to pay his health expenses. He said that:

I have national health insurance that usually I use to pay. As for the other services that the health insurance does not cover, I apply for the common fund and pay with it (Participant 18, a male with hearing disability).

4.2.3 Communication Barriers

In terms of communication barriers, the findings of the study indicate that participants, especially those with hearing disability faced challenges in communicating their health needs with health professionals. The participants with hearing disability complained about how they believed they did not get the services they needed because they did not go to the hospital or pharmacy with an interpreter neither did the hospital or pharmacy have one. Hence, they could not communicate effectively with health professionals. This is evident in these statements made by some participants:

I remember there was a time I went there alone and when I dropped my card, they were calling me and I didn’t even hear; they came to me and I did not understand because I did not go with my sign language interpreter. They just gave me the paper and said they had finished, I should go home. Because I did not understand I left. My health problem was not solved. But with the interpreter, he will interpret for me and I will understand everything. When I use an interpreter, the understanding comes clear (Participant 1, a female with hearing disability).

The only challenge I can say is that sometimes when I go to the pharmacy in my neighborhood and tell them what is wrong with me and they give me medicine, I do not get well when I take it. This is because the pharmacists are unable to do
sign language and I also have difficulty explaining what is wrong with me
(Participant 6, a woman with hearing disability).

The participants with hearing disability noted that due to the lack of sign language interpreters at the health facilities, health professionals sometimes communicated with them through written texts. However, some of the participants complained that they had difficulty understanding the texts since not all of them were educated to read English as narrated below:

*Sometimes health professionals choose to communicate with me through writing in English and I hardly understand what they write. This is because I am not able to read* (Participant 1, a female with hearing disability).

*The health professionals write information on paper for me, but sometimes I do not understand some of the words. They do not even have basic sign language skills and sign language interpreters. This has always been our complaints, but they do not mind us. A hearing person will talk and write on paper, but you will not even understand* (Participant 2, a female with hearing disability).

Another medium of communication used by participants with hearing disability was through gestures as narrated by one of the participants.

*The problem is at the health facility because there is no sign language interpreter I resort to going to the pharmacy to buy medicine when I am sick. The pharmacist and I communicate through gestures* (Participant 17, a male with hearing disability).

Interestingly, without sign language interpreters, persons with hearing disability risked receiving wrong diagnosis and medications from health professionals which complicated their conditions. This assertion was confirmed by a participant that:

*Without sign language interpreters we are always at risk of receiving the wrong medicine from health professionals* (Participant 18, a male with hearing disability).
4.2.4 Transportation Barriers

Three main sub-themes emerged out of transportation barriers: cost, inaccessible vehicles and lack of destination signs.

Cost

The study found that the high cost of transportation was a challenge participants with physical disability encountered when accessing healthcare at the hospitals. Some study participants with mobility, hearing and visual disabilities emphasized that they had challenges paying for the cost of transportation which became a hindrance for them to access healthcare.

*The cost of transportation is a challenge. It is expensive. If I do not have money to pay, I have no option than to walk* (Participant 9, a male with visual disability).

*The other time I was asked by a doctor to go to Nima to buy a drug. As you can see, it is difficult for me to go somewhere in my wheelchair so I had to board a taxi which is expensive* (Participant 4, a female wheelchair user).

*When I am going to the hospital, I encounter a lot of challenges. The high cost of transportation discourages me from going to the hospital to access healthcare* (Participant 1, a female with hearing disability).

The study further reveals that participants with visual disability incurred an additional cost of transportation whenever they accessed healthcare at hospitals because they paid the transportation fare of their sighted guides.

*Whenever I go to the hospital, I go with a guide who provides me with assistance. Going with him means I have to also pay his transportation fare, which is an extra cost. It is not easy. I always have to ensure that I have his fare in addition to mine before leaving the house* (Participant 11, a male with visual disability).
Inaccessible Vehicles

Apart from the cost of transportation, persons with mobility disability also reported that minibuses (trotros) were not accessible. However, they boarded those cars because they did not have money to pay for the taxi fares which were expensive. The voices below are narrations of study participants:

*I cannot hire a taxi to the hospital because I do not have the means so I usually go with a trotro. The distance to the health center is a problem. The vehicles are not accessible. A lot of vehicles in Ghana are not accessible for persons with disabilities. Even the Metro Mass Transit bus is not accessible* (Participant 3, a male wheelchair user).

*All the trotro I board to the hospital are not accessible. People sometimes assist me to get on the bus. At times too, I manage to climb. Because I do not have money I pick trotro and not taxi to the hospital. Taxis are expensive* (Participant 20, a female crutches user).

Due to the inaccessible nature of some vehicles, persons with mobility disability, particularly wheelchair users complained that in an attempt to climb into the vehicles, they sat on the vehicle access stairs and dragged themselves into the vehicle which dirtied their clothes. A participant who had to contend with this situation said:

*If you have realized, a wheelchair user will always have his clothes becoming dirty whenever boarding the car because where you place your shoes when climbing the vehicle is where we usually sit to climb* (Participant 3, a male wheelchair user).

In their efforts to board the inaccessible vehicles, some participants with mobility disability mentioned that they sustained injuries. This scenario is evident in a participant’s complaint that:
Even though the vehicles are not accessible, I manage to climb. The vehicles tear my dresses and sometimes I sustain injuries when I climb (Participant 20, a female crutches user).

Lack of Destination Signs

Persons with hearing disability also experienced transportation challenges in accessing healthcare. They reported that the lack of destination signs on vehicles was a transportation barrier in accessing healthcare. This is because bus conductors did not signal while calling for passengers and vehicles did not also have destination signs so they mostly ended up at wrong destinations as stated below:

One day I was going to a hospital at Circle and because of my condition, I could not hear the mate shout Circle! Circle! Circle! I ended up going to a different destination because I was unable to locate the right vehicle. If there had been a destination sign on the vehicle or the mate has used his hand to do the circle sign, I would have understood (Participant 1, a female with hearing disability).

Moreover, attitudes of few drivers and their mates worsened the transportation problems of some study participants. For example, a man with mobility disability noted that anytime he went to the roadside to board a vehicle to the health facility to access healthcare, surprisingly drivers increased their speed in order not to stop and pick him because of his condition. The bitter treatment meted out to him is captured in these words:

When some drivers see me by the roadside, they intentionally increase their speed because they know I will stop them. The drivers do not want to pick me even if I tell them I am going to the hospital. This is because I am a wheelchair user (Participant 3, a male wheelchair user).

4.2.5 Attitudinal Barriers

In terms of attitudinal barriers, it was observed that although some health professionals exhibited
positive attitudes such as being pleasant towards persons with physical disability, other health professionals negatively reacted towards them in their attempt to render services to them. Study participants indicated that some health professionals, specifically, doctors, nurses and laboratory technicians exhibited negative attitudes towards them when they visited the hospital to access healthcare. A man with visual disability mentioned that a doctor he used to visit spoke to him in a rude manner that made him feel unhappy. This unethical treatment was expressed by the participant thus:

*My doctor at a private hospital I used to visit was a politician and wasn’t always at post because he was campaigning for elections so I was referred to another doctor. I went to the new doctor one day and told him I feel dizzy. He asked how I, a blind person knows I feel dizzy. I wasn’t happy at all. I wasn’t happy with the way the doctor spoke to me. Since then I haven’t been to that hospital. I go to Adabraka Polyclinic whenever I am sick* (Participant 7, a male with visual disability).

Women with hearing disability stated that health professionals, mostly the nurses laughed, provoked and often made sarcastic remarks against them when they go to hospitals with pregnancies. This was what a woman with hearing disability said:

*If you are a deaf person and you get pregnant, the nurses will provoke, ridicule and tease you when you go to the hospital. This is not good. It happens in all the hospitals, I cannot single out any hospital. The behavior they put up towards women is very bad* (Participant 1, a female with hearing disability).

Some persons with physical disability mentioned that a number of nurses looked down on them when they visited the hospital to access healthcare. A participant who was disdainfully treated remarked:

*Because of my condition, the nurses look down on me whenever I visit the hospital and their language is very bad. The nurses are the worst health professionals*
compared to the doctors (Participant 12, a male with visual disability).

Furthermore, the study findings indicate that laboratory technicians were mostly impatient with persons with physical disability. A female participant who suffered from impatient laboratory technicians remarked:

As for the nurses, there is a problem. The nurses are not nice. When the laboratory technicians are talking to me they are not patient. They can ask me to go out if I cannot talk to them. You can see that they are mean (Participant 1, a female with hearing disability).

It is worthy to note that other service seekers exhibited negative attitudes towards persons with physical disability. A woman with visual disability said that some service seekers did not want to have body contact with her. The narration below is an example of this scenario:

Some service seekers do not even want me to touch them when I am coming. I do not know if they think my disability is contagious (Participant 19, a female with visual disability).

4.2.6 Inadequate Knowledge of Health Professionals on Disability Issues

Various opinions were given by study participants regarding the knowledge of health professionals about disability issues. Some noted that health professionals, especially nurses did not have any form of knowledge about disability issues. This has been described in the narratives below:

You can see that the nurses do not have any knowledge about disability that is why they treat us this way. Their behavior towards us is appalling (Participant 1, a female with hearing disability).

I am not sure they are knowledgeable about disability issues. To me, I will say they are not knowledgeable because if they do, they would know how to treat a person with physical disability. You know persons with physical disability do
things differently from those without disabilities. They are not experienced in disability issues. If they do, they would do everything in accordance with our needs (Participant 4, a female wheelchair user).

 Others were of the view that few health professionals had some knowledge on disability issues. A participant who holds this view stated:

    It is only a few of them who are knowledgeable about disability. A lot of them lack information about disability. They do not know how to provide treatment to us (Participant 8, a male with visual disability).

 Some participants were of the view that the lack of knowledge of health professionals about disability issues and how to treat persons with disabilities made them behave rudely towards persons with physical disability. This observation is evident in this candid opinion expressed by a participant:

    I will base their lack of knowledge on their attitude. If you have a bad attitude you will definitely not treat us well. Those with good attitudes are caring. Not all of them have knowledge about disability, but some do have. With regards to knowledge about our needs, I do not think they have because if they do, they would be giving us special care. If I say special care, I mean a person in a wheelchair should be treated differently from other able bodied persons because of his or her condition. The special care also includes not letting the person spend more time before receiving treatment (Participant 11, a male with visual disability).

4.3 Objective Two: Strategies Persons with Physical Disability employ when they are ill

Under the second objective which was to identify strategies persons with physical disability in the Accra Metropolis employ when they were ill, themes derived from the study findings were hospital care, pharmacy visit, self-medication and exercising faith.
4.3.1 Hospital Care

Although study participants reported that they visited the hospitals when they were ill, hospital seems to be the last resort. They resorted to several measures before going to the hospital. Some participants said that because they disliked taking medicines, they would rather keep the illness to themselves and go to the hospital when their health conditions became intolerable.

*When I am sick, because I do not like taking medicines, I keep it to myself, until maybe it becomes unbearable for me before I seek medical help at the hospital. Mostly, I go to the hospital whenever I realize that I am very sick* (Participant 19, a female with visual disability).

A participant with mobility disability affirmed that when she is ill, she would stay indoors, sit idle or keep the illness to herself and go to the hospital only when her health condition worsened.

*When I am sick, it is either I sit down or I am in the room, which is at the initial stage of the illness. When it becomes critical, then I go to the hospital to access healthcare* (Participant 20, a female crutches user).

The findings of the study also reveal that some of the participants resorted to first aid when they were ill and went to the hospital later on when their illnesses became critical as narrated:

*When I am sick, the first thing I do is to go for first aid. First aid is medicines I usually buy from the pharmacy to keep and use whenever the need arises. If after the first aid I am still not better, I go to the hospital to see the doctor* (Participant 8, a male with visual disability).

*I normally take first aid when I am sick. When the illness persists, then I go to the hospital for healthcare* (Participant 12, a male with visual disability).

4.3.2 Pharmacy Visit

The study findings show that persons with physical disability in the Accra Metropolis also
accessed healthcare from pharmacy shops when they were ill. Some persons with physical
disability resorted to buying medicine from pharmacy shops to help cure their illnesses because
of its proximity to their houses as commented below by a participant.

*If I do not go to the hospital when I am sick, then the pharmacy shop is the next
option for me to get treatment. The pharmacy is in this area. I do not board the
vehicle. I walk to the pharmacy whenever I am sick to buy medicine to heal my
sickness* (Participant 11, a male with visual disability).

Rather than the proximity of pharmacy shops to their houses, some participants sought healthcare
from the pharmacy shop when they were ill because they claimed the medicines were cheaper
than going to the clinic or hospital. Below is what a participant said:

*I go to the pharmacy shop to access healthcare because the medicine they give me
is cheaper. Even though the pharmacists are not able to sign they use gestures to
communicate with me. If they give me the medicine they demonstrate with their
fingers “morning two” and “evening two”. When I am sick, I only take medicine*
(Participant 2, a female with hearing disability).

It is also important to note that, while some participants accessed healthcare from pharmacies
when they were ill, others visited pharmacies to buy medicines prescribed by doctors from the
hospital as described by participant four below:

*When I visit the hospital the doctors sometimes ask me to go and buy some of the
medicines they write for me at the drug store. The other time I was asked by a
doctor to go to a pharmacy in Nima to buy a drug* (Participant 4, a female
wheelchair user).

**4.3.3 Self-Medication**

Self-medication was a strategy few participants employed when they were ill and could not
access hospitals for treatment due to the high cost. Participants did self-medication by
prescribing their own medicines for their illnesses, mostly, medicines they might have taken previously or something someone else close to them has prescribed as evident in this narrative:

When I go to the pharmacy I sometimes tell them to give me medicine of my choice. For example, if I am having a headache, I can choose to ask them to give me the medicine I think will heal me (Participant 11, a male with visual disability).

The findings of the study also reveal that some study participants resorted to herbal medication when they were ill. Few participants prepared their own herbal medicines when they were ill while others bought herbal medicines. Participants who prepared their own herbal medicines noted that they did not buy the herbs, rather, they searched for herbs to prepare medicines. Below are narrations by participants three and five respectively:

I self-medicate by looking for my own herbs and cooking them. I learned that from my grandmother. The herbs are easy to get and I do not also buy them (Participant 3, a male wheelchair user).

If I am sick and do not go to the hospital, I use herbs. I cook my own herbs. I don’t even buy the herbs (Participant 5, a male with visual disability).

Sometimes the herbal medicine they prepared was abused. This was as a result of lack of knowledge about the dosage to take as narrated below:

A challenge with the taking of herbal medicine which I prepare is that I do not know the quantity I am supposed to take. I end up abusing the medicine. This gets me scared. I do not know if the medicine will affect me later in life. Anyway, I do not care because I do not see it (Participant 3, a male wheelchair user).

Few participants with visual disability who bought herbal medicine from pharmacies or herbal shops also abused the drugs. This was because they did not always find people to read the inscription on herbal medicine as commented by a participant with visual disability.
Sometimes, I do not know the dosage I am to take unless I get someone to read for me. Other times, I have to use a cup to measure the quantity of medicine I am to take, because of my condition I don’t know if I am overdoing it or under doing it if I don’t have sight assistance. Again, if there is a note attached to the medicine, I can’t read (Participant 13, a female with visual disability).

Nonetheless, a few study participants disclosed that even though they used herbal medicines, they bought them from the pharmacy as narrated below:

I buy herbal medicines when I am sick. I do not go to the herbalist. I rather visit the pharmacy for medicine (Participant 7, a male with visual disability).

I like taking herbal medicine when I am sick. Sometimes, I send any of my children to get it for me from the pharmacy. I do not go to the herbalist (Participant 21, a male wheelchair user).

4.3.4 Exercising Faith

Another strategy persons with physical disability in the Accra Metropolis employed when they were ill was to exercise their faith by praying to God for healing. With respect to spiritual healing, a participant with mobility disability confirmed that:

Sometimes when I am not feeling well and I do not have money, I do not go to the hospital. You see we all believe in prayers. I just pray and drink water (Participant 3, a male wheelchair user).

When I am sick, I will just be there. I will pray, drink water or sleep. It is all about money. Sometimes I do not take medicine. For instance, I am coughing now, but because there is no money, I have to be chewing ginger (Participant 20, a female crutches user).

4.4. Objective Three: Measures for Improvement in Healthcare

The third objective was to find out what participants suggest as ways of improving healthcare
provided by health professionals in the Accra Metropolis. The themes that emerged from the findings of the study were: disability studies as part of the academic curriculum, availability of disability desk, availability of sighted guides and sign language interpreters at health facilities, accessible furniture, and washrooms. Several suggestions were made by the study participants to help minimize barriers in accessing healthcare to improve services provided by health professionals in the Accra Metropolis. Some participants, mostly those with mobility disability proposed that beds and washrooms in hospitals should be made accessible as evident in these narratives:

The hospital authorities must ensure that hospital beds are accessible so that as soon as you get off the wheelchair you can climb the bed easily. They have to understand that we are not the same as those without disabilities. It is not all of us who want to be lifted up at the hospital. The fact that I have a disability does not mean I am bedridden. The authorities should do something about the inaccessible health facilities. The washrooms should also be accessible for wheelchair users at the hospital (Participant 4, a female wheelchair user).

In addition, persons with hearing disability advocated for the need for sign language interpreters within every health facility in the Accra Metropolis. These suggestions are described in the following comments:

To improve services provided by health professionals for persons with hearing disability at the hospital, sign language interpreters should be present at all times (Participant 6, a female with hearing disability).

We need the services of an interpreter for us the deaf. All the healthcare facilities must have sign language interpreters. When we talk about accessibility for deaf people it is about sign language interpreters (Participant 1, a female with hearing disability).

Persons with visual disability recommended that braille machines should be made available to
enhance their communication with health professionals at health facilities. A participant who advocated for the provision of braille machine said:

> There should be braille machines at health facilities so that we can also read when we go there. This will ensure effective communication with people at the hospital (Participant 13, a female with visual disability).

Interestingly, a number of persons with visual disability proposed that there should be sighted guides at health facilities to provide them with assistance as indicated below:

> Where visually impaired persons like me are concerned, we need sighted guides to move from one place to another at the hospital (Participant 13, a female with visual disability).

Also, study participants suggested that the study of disability issues be made a part of the academic curriculum for health professionals in their training schools. This was what some study participants had to say:

> To improve healthcare provided by health professionals, schools’ curricula should take into consideration issues of PWDs. Disability should be added to the courses at training schools for health professionals (Participant 3, a male wheelchair user).

> If health professionals are given adequate training on disability, it will help improve the services they provide for us. This will be possible if the disability is added to courses at the training schools for the doctors and nurses (Participant 8, a male with visual disability).

It is important to note that some participants suggested that there should be disability desks at health facilities for persons with physical disability. They proposed that the personnel at the desk should be knowledgeable about disability issues as indicated below:

> Well, I would like to suggest that there should be a disability desk at the health facility. It should be the first point of call for persons with disabilities upon entry
at the health facility. The disability desk should be occupied by someone trained in disability issues so that as soon as I enter this person will be able to identify that I am visually impaired and assist me accordingly (Participant 13, a female with visual disability).

4.5 Discussion of Findings

This study explored access to healthcare for persons with physical disability in the Accra Metropolis. This section discusses the study findings. The discussions are based on the objectives of the study, which are barriers persons with physical disabilities encounter in accessing healthcare and the strategies they employed when they were ill. Moreover, the findings are juxtaposed with the reviewed literature especially, to know if some of the findings relate to existing findings and, especially, what new findings this study has been able to make towards research in the area of persons with physical disability. Recommendations participants outlined on how health professionals can improve healthcare for persons with physical disability are also captured in this section.

4.5.1 Barriers in Accessing Healthcare by Persons with Physical Disability

Access to quality healthcare is very important in improving well-being. However, it is evident from the study findings that persons with physical disability encountered several barriers in accessing healthcare. The study suggests that persons with mobility disability were more likely to experience physical barriers than those with visual and hearing disabilities. Study findings show that inaccessible entrances to the hospital, offices, laboratories, OPDs, pharmacies as well as washrooms were physical barriers persons with mobility disability encountered in accessing healthcare. This observation supports the finding by Badu, Agyei- Baffour and Opoku (2016) in the Kumasi Metropolis, which revealed that persons with physical disability encountered barriers
such as inaccessible entrances when accessing healthcare.

The current study found that entrances of health facilities were not accessible because they had no ramps, steep, rough and narrow ramps. This made it difficult for persons with mobility disability, particularly wheelchair users to use the entrances of health facilities. This situation could also affect service delivery at the hospital since some of the participants, especially; wheelchair users receive healthcare services outside the doctors’ offices. Findings relating to lack of accessible ramps, steep, rough and narrow ramps which are found in this study support several other studies in Canada by Veltman, Stewart, Tardif and Branigan (2001) and in Namibia by Amadhila (2012). Also, it is worthy to note from the findings that inaccessible ramps and stairways were not the only physical barriers persons with physical disability, especially mobility disability encountered at health facilities. They also had difficulty using hospital equipment such as height rods and weighing scales because they were not accessible. This could be attributed to the fact that the height rods and weighing scales were not designed to meet the needs of persons with mobility disability. This corroborates studies by Badu et al. (2016), Kroll, Jones, Kehn and Neri (2006) which states that hospital equipment is often not accessible for people with disabilities, particularly those with mobility disability. The findings of this study also demonstrate that beds in admission wards, laboratory chairs, examination tables and chairs in consulting rooms and OPDs were not accessible for persons with mobility disability.

In addition, the study reveals that women with mobility disability had difficulties accessing beds in scan rooms and labor wards at hospitals during pregnancy. This is because the beds were high. Apart from lack of access to entrances of hospitals and offices as well as inaccessible furniture, this study reveals that poor arrangement of furniture in doctors’ offices, laboratories and OPDs, as well as inadequate turn-around spaces at admission wards restricted the movement of persons
with mobility disability, especially, those who use wheelchairs at hospitals. This study also indicates that counters at records departments and pharmacies were inaccessible for persons with mobility disability. Surprisingly, the barriers in hospitals were not different from some pharmacies. The study indicates that the surroundings, entrances and inside of pharmacies in the Accra Metropolis were not accessible for persons with physical disability. The surroundings had uncovered drainages, there were no ramps and the presence of inaccessible stairs in front of the shops restricted movement of some persons with mobility disability. These compelled some of them to receive healthcare outside the pharmacy shop.

The current study also found that washrooms in some health facilities were inaccessible to persons with physical disability. The accessibility of washrooms depends on the form of disability and the assistive device used. The washrooms in some hospitals were not accessible for persons with mobility disability, especially wheelchair users because the entrances were narrow. Hence, while some of them had to crawl to access the washrooms, others had to be provided with assistance. From the study findings, it is obvious that the needs of persons with physical disability were not taken into consideration when constructing health facilities.

It is important to note that financial barrier was a key challenge to healthcare for persons with physical disability in the Accra Metropolis. The findings of this study indicate that few persons with physical disability faced the problem of inadequate finance in paying for their health expenses. This confirms findings from the works of Mccoll, Jarzynowska and Shortt (2010), Rooy, Amadhila, Mufune, Swartz, Mannan and Maclachlan (2012) and Drainoni, Tobias and Maisels (2006) which reported that financial constraints influenced access to healthcare for persons with disability at health facilities. However, it is evident from this study that persons
with physical disability who were not employed were more likely than those who were employed to experience financial challenges when accessing healthcare.

In addition, the study findings indicate that a number of persons with physical disability relied solely on financial assistance from family members, friends and from the government in the form of the District Assembly Common Fund. Although there is a health policy which is the National Health Insurance Scheme (NHIS) to support the health needs of all individuals including persons with physical disability, information gathered from this study show that persons with physical disability encounter institutional barriers when accessing healthcare. Regarding institutional barriers, the study findings reveal that the NHIS did not cover all medical expenses of persons with physical disability. This situation resulted in some participants feeling reluctant to access healthcare when they were ill. This confirms the Social Model of Disability that institutional barriers such as policies discriminate against persons with disabilities (Shakespeare and Watson, 2002). Persons with physical disability could have accessed healthcare if the NHIS covered the unique health issues that relate to their disability and other medical expenses such as cost of rehabilitation services and assistive devices.

A further barrier to healthcare for persons with physical disability was communication barrier which mostly affected persons with hearing disability. The study findings show that persons with hearing disability encountered challenges communicating their health needs to health professionals. This validates the studies of Hwang, Johnston, Tulsky, Dyson-hudson, Wood and Komarof (2009) and Scheer, Kroll, Neri and Beatty (2003) which reported that persons with disabilities experience inadequate communication with health providers that usually result in their inability to express distress in the usual way. Persons with physical disability face communication barrier because, some hospitals they visited did not have sign language
interpreters to interpret conversations between them and health professionals. Due to this, some of them had to put what their problems were in writing. Lack of sign language interpreters at health facilities impedes the chances of persons with hearing disability from receiving adequate healthcare (Mprah, 2013; Hussey, MacLachlan & Miji, 2017). This could further worsen their health condition. Also, in order to ensure effective communication between health professionals and persons with hearing disability, hospitals could have employed sign language interpreters to sign and interpret information for them but this was not done.

Furthermore, another key barrier identified in this study was transportation. The study findings show that high cost of transportation hindered access to healthcare for persons with physical disability. Compounding the problem of high cost of transportation is the fact that vehicles specifically minibuses were not also accessible for persons with mobility disability in the Accra Metropolis which usually pose a huge challenge for them. While some crawled into inaccessible vehicles and got their clothes dirtied; others were helped like children into the buses. All of these barriers affected their ability to access healthcare. Persons with physical disability possibly could have used taxi services as means of transportation because they were accessible, that is, lower and easy to climb compared to minibuses but they could not afford to pay for the cost of taxi fares. This is consistent with the literature indicating that public vehicles are not accessible for persons with disability (Naami, 2014). Also, in conformity with this finding, the Social Model emphasize that transportation barriers such as inaccessible public vehicles restrict the movement of persons with disability (Barnes and Mercer, 2005). Moreover, the study findings point out that lack of destination signs on vehicles was a transportation barrier for persons with hearing disability when accessing healthcare. Because of this, they boarded vehicles without knowing the destinations.
Regarding attitudinal barriers, this study like others reports that doctors, nurses, laboratory technicians and other service seekers alike exhibited negative attitudes towards persons with physical disability at health facilities (Scheer et al., 2003; Amadhila, 2012). Examples of such attitudes exhibited in this study were provoking, teasing, being rude and treating them as inferior. These findings confirm the assumption of the Social Model of Disability which posits that persons with disabilities encounter negative attitudes which undermine their status in society (Lang, 2007). These findings also validate studies by Vergunst (2016) which found that persons with disabilities encounter negative behaviors while interacting with health professionals and are also treated worse at health facilities as compared to those without disabilities. Additionally, the study findings reveal that negative attitudes demonstrated by health professionals towards study participants was as a result of their inadequate knowledge about disability issues and needs of persons with physical disability. The study found that though some health professionals were knowledgeable about disability issues, they had no idea about how to treat persons with physical disability. This observation complements the findings of studies from Canada (Veltman, Stewart, Tardif & Branigan, 2001), Ghana (Inclusion Ghana, 2013) and Zimbabwe (Choruma, 2007) which found that inadequate knowledge of healthcare providers regarding disability issues resulted in unmet healthcare needs of persons with physical disability.

4.5.2 Strategies Persons with physical disability employ when they are ill

Different views and experiences were shared by persons with physical disability in the Accra Metropolis regarding the strategies they employed when they were ill. The study found that strategies persons with physical disability in the Accra Metropolis employed when they were ill include: seeking hospital care, pharmacy visit, self-medication and exercising their faith. In connection with hospital visit, an interesting finding to note in this study is that some persons
with physical disability visited the hospital when their illnesses became critical after using first aid. Beside hospital care, study findings reveal that pharmacy visit was another strategy used by persons with physical disability in the Accra metropolis when they were ill; confirming a study by Palmer, Nguyen, Neeman, Berry, Hull and Harley (2011) which states that persons with disabilities in Vietnam resorted to pharmacy services when they were ill rather than visiting the health facility to access healthcare.

Findings from this study also indicate that participants accessed healthcare from pharmacies because it was cheaper compared to visiting hospitals. In addition, other participants noted that they employed self-medication when they were ill by prescribing their own medicines for their illnesses when they went to pharmacies. This finding validates the findings of Amadhila (2012) who found that in Namibia, persons with physical disability, as part of self-medication personally bought painkillers from the pharmacy to ease their illness. The study outcome shows that not only hospital care and pharmacy visit were accessed by persons with physical disability in the Accra Metropolis when they were ill, few of them also resorted to self-medication which validates Imoro (2015) study. The author found that the difficulties in accessing healthcare by persons with disabilities and their inability to deal with these problems compelled some of them to resort to certain strategies such as self-medication when they were ill.

Moreover, herbal medication was another strategy persons with physical disability employed when they were ill. They bought the herbal medicines from pharmacy shops or prepared them themselves rather than visiting herbalists as in the case of Namibia (Amadhila, 2012) and Uganda (Mulumba, Brolan, Ruano, Brooker & Hammonds, 2014). Surprisingly, this study found that some participants abused herbal medicines. Participants with visual disability abuse it because they could not read the dosage from the inscriptions. Other study participants abused the
herbal medicines they prepared because they did not know the right dosage to take. The abuse of herbal medicines could lead to other medical complications.

Additional finding of this study is that based on the negative perceptions society has about disability and the barriers persons with physical disability face such as financial, attitudinal, communication and physical in accessing healthcare, some persons with physical disability in the Accra Metropolis exercised their faith by praying for healing when they were ill instead of visiting the hospital. The study findings also demonstrate that few persons with physical disability in the Accra Metropolis slept when they were ill corroborating a study in Canada which reported that, sleep and relaxation are useful approaches persons with disabilities adopted when they were ill (Hutchinson, Loy, Kleiber & Dattilo, 2003).

4.5.3 Measures for Improvement

To help improve healthcare provided by health professionals for persons with physical disability, participants proposed that beds and washrooms in hospitals should be made accessible. Findings of the study also show that the availability of sign language interpreters at health facilities would improve services provided by health professionals. In addition, to improve healthcare, knowledge of health professionals on disability issues should be enhanced by making the study of disability issues a part of the academic curricula for health professionals in their training schools. Furthermore, when participants were asked to recommend measures that could improve access to their healthcare they suggested the availability of disability desks at health facilities for persons with physical disability. Finally, sighted guides at health facilities were also recommended as a way to improve healthcare for persons with visual disability.
CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

Chapter five of this study comprises the summary and conclusions based on the findings. Recommendations for improvement of healthcare for persons with physical disability have also been made based on the findings of this study. Furthermore, the study has outlined the implications for social work practice and education on how to assist persons with physical disability in the Accra Metropolis.

5.1 Summary of Findings

The study explored access to healthcare for persons with physical disability in the Accra Metropolis. The objectives of this study were to identify the barriers persons with physical disability encountered in accessing healthcare, strategies they employed when they were ill and what participants suggest as ways of improving healthcare. In-depth interviews were carried out to solicit information from participants with the aid of an interview guide. Twenty-one participants were purposively sampled for this study. The study participants comprised seven each of persons with hearing, visual and mobility disabilities. The data was also analyzed using Braun and Clarke (2006) six steps of thematic analysis of qualitative data.

The study findings indicate that barriers encountered by persons with physical disability in accessing healthcare include: physical barriers (example: inaccessible entrances, lack of ramps), financial barriers, communication barriers (such as lack of sign language interpreters), transportation barriers (for instance: inaccessible vehicles, high cost of fares), attitudinal barriers
and inadequate knowledge of health professionals on disability issues. Furthermore, the findings of the study reveal that persons with physical disability in the Accra Metropolis employed hospital care, pharmacy visit, exercising faith and also self-medicated through the use of herbs when they were ill. From the findings, persons with physical disability suggested that, to improve healthcare provided by health professionals, there should be sighted guides at health facilities to provide assistance to persons with hearing disability. Participants also proposed availability of disability desks at health facilities and the study of disability issues as part of the academic curriculum for health professionals in their training schools as ways of improving healthcare.

5.2 Conclusions

It is obvious from the study findings that access to healthcare is a complex issue for persons with physical disability in the Accra Metropolis. The difficulties persons with physical disability in the Accra Metropolis encountered in accessing healthcare were due to barriers. The study concludes that physical, financial, communication; transportation and attitudinal barriers exist and limit access to healthcare for persons with physical disability in the Accra Metropolis. This resulted in the majority feeling reluctant to access healthcare and this affected their health status. The study also concludes that in their quest to recover when they were ill, persons with physical disability employed several strategies some of which were detrimental to their health. There is, therefore, the need to address the issues associated with healthcare for persons with physical disability.
5.3 Recommendations

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

- The study recommends that policymakers should reform the National Health Insurance Policy to cover the cost of rehabilitation services and assistive devices as well as unique health issues that relate to the condition of persons with physical disability since it could help eliminate the financial barriers they face in accessing healthcare.

- Furthermore, there is a need for hospital administrators to ensure that medical equipment at health facilities are accessible to persons with physical disability. This will help eliminate the barrier of access to and lack of hospital equipment persons with physical disability encounter at health facilities when accessing healthcare.

- The researcher recommends that the government through hospital administrators should construct ramps at health facilities that are accessible to persons with mobility disability. This decision should be taken in conjunction with persons with mobility disability. This recommendation is based on the finding that ramps at health facilities were inaccessible to persons with mobility disability in the Accra Metropolis.

- There is the need for the government through the Ministry of Health and Ghana Health Service to collaborate with institutions such as Organisations for Persons with Disability and Non-Governmental Organizations to organize workshops for health professionals to enhance their knowledge on disability issues and how to effectively provide treatment to persons with physical disability at the various health facilities. This will help improve services health professionals provide to persons with physical disability at health facilities.
Furthermore, hospital administrators should consult persons with physical disability, especially wheelchair users to come up with the best ways of arranging chairs in the doctors’ offices and OPDs to ensure free movement from one place to another. This recommendation is based on the finding that inadequate turn-around space restricted movement of persons with mobility disability in hospitals.

5.4 Implications for Social Work Practice and Education

The findings of this study have various implications for social work practice and education in Ghana. They include:

- Social workers as educators could liaise with the Ministry of Health, Ghana Health Service, National Council for Persons with Disability and other stakeholders to come together and provide education on disability issues for health professionals in the various health facilities in Ghana.

- In addition, the mainstream media could be used by social workers as a means to educate the general public about the health needs of persons with physical disability.

- Social workers could also advocate for an expansion in the National Health Insurance Scheme and the District Assembly Common Fund to address the unique health needs of persons with physical disability.
REFERENCES


APPENDIX A

INTERVIEW GUIDE FOR PARTICIPANTS

(PERSONS WITH PHYSICAL DISABILITY)

ACCESSING HEALTH CARE IN GHANA: EXPERIENCES AND PERCEPTIONS OF PERSONS WITH PHYSICAL DISABILITIES IN THE ACCRA METROPOLIS

This survey seeks to collect information about the experiences of persons with physical disabilities in accessing health care in the Accra Metropolis. The information derived from the survey will help policy makers to review existing policies and implement appropriate policies to improve health care access for persons with physical disabilities in Ghana. Thank you.

Section I: Demographic information

1. What is your age? .........................

2. What is your educational level? Please mark the one that applies to you.
   a. Elementary education
   b. Junior High education
   c. Senior High education
   d. Completed technical or vocational school
   e. Others........................................ Please specify........................................

3. What is your religious affiliation? Please mark the one that applies to you.
   a. Christian
b. Muslim

c. Traditional religion

d. Other religion……………………….. Please specify……………………………

4. What is your marital status? Please mark the one that applies to you.

   a. Single

   b. Co-habituating

   c. Married

   d. Separated

   e. Divorced

   f. Widowed

5. Do you work? a. Yes………….. b. No……………..

6. If yes, are you

   a. Self employed

   b. Work in the government sector

   c. Work in the private sector

7. What is your occupation? ........................................

8. What is your monthly income? ...............................
9. Do you have children?  
   a. Yes ............  
   b. No ................

10. If yes, how many children do you have? ............

11. What form of physical disability do you have? Please mark the one that applies to you.
   a. Visual disability
   b. Hearing disability
   c. Mobility disability

12. How long have you been with this form of disability? .....................

Section II: Access to health care

1. What do you do when you are sick?

2. If you go to the hospital, how long do you usually stay at the hospital before receiving treatment?

3. Are you given priority when you visit the hospital for healthcare services?

4. How will you describe accessibility of equipment (X-ray machines, scanning machines, laboratory chairs, examination chairs and other equipment) used in treatment in the hospital?

5. What are the barriers you encounter in accessing healthcare?

6. What are the architectural barriers you encounter that restrict your movement in health facilities?
7. Tell me about the challenges you encounter with hospital doors, entrances to as well as the inside arrangements of the following places; doctors’ offices, laboratory rooms, X-ray rooms, wash rooms, pharmacy, Out-Patient-Department (OPD), records department, labor wards and admission wards.

8. How do you pay for healthcare services at health facilities?

9. Do you have challenges paying for your hospital expenses? If yes, what are the challenges you have in paying for hospital bills (laboratory tests, prescribed drugs among others)?

10. In your opinion, what are the attitudes of health professionals specifically doctors, nurses and laboratory technicians towards you at health facilities?

11. What positive and negative attitudes do you experience from other service seekers at the health facilities?

12. Tell me about your means of transportation to the health facilities.

13. Tell me about the transportation barriers such as inaccessible vehicles and cost of transportation to the healthcare facilities.

14. Do these barriers affect your access or going to the hospital? If yes, how?

15. How do you perceive health professionals’ knowledge about disability and needs of persons with physical disabilities?

Section III: Strategies employed when ill

1. If you do not go to the hospital when you are sick what do you do?
2. Do you do self-medication?

3. Do you visit the herbalist?

4. Do you go to prayer centers?

5. What challenges do you encounter with these other services or strategies you adopt?

Section IV: Suggestions for improvement

6. What would you suggest as ways to help improve services provided by health professionals specifically doctors, nurses and laboratory technicians at the hospitals?

7. What mechanism can be put in place to reduce or eliminate the barriers persons with physical disabilities encounter in accessing health care at hospitals?
APPENDIX B

CONSENT FORM

ACCESSING HEALTH CARE IN GHANA: EXPERIENCES AND PERCEPTIONS OF PERSONS WITH PHYSICAL DISABILITIES AND HEALTH CARE PROFESSIONALS IN THE ACCRA METROPOLIS

The researcher is Rachael Abrokwah, an MPHIL student of the University of Ghana, Department of Social Work conducting a study on the above topic. The researcher modestly asks for your participation in an interview to obtain information and understanding on her research topic. Participation is voluntary and you can decide to opt out at any stage of the research.

Purpose of the Study

This study is aimed at exploring the experiences and perceptions of persons with physical disabilities and health professionals in accessing health care at health facilities in the University of Ghana. Specific objectives of the study are to find out (a) the barriers persons with physical disabilities face in accessing health care (b) strategies persons with physical disabilities employ when they are ill and (c) explore the perceptions of health professionals in the Accra Metropolis about the challenges persons with physical disabilities encounter in accessing health care. The study is solely for academic purposes and will contribute to the award of a Masters Degree in Social Work.
Participation

Your participation in this study is voluntary; therefore you can withdraw anytime you want during the data collection process. If you decide to withdraw your participation, any information given will not be used.

Confidentiality

Any personal information about you will remain confidential. Any quotations that will be used in reporting the findings will exclude names or any information that can be traced back to you. All recordings and transcripts will only be accessible to the researcher and her supervisors and it will be stored properly to avoid others from gaining access to your information. The findings will be submitted as part of the researcher’s Master’s Degree thesis and may be published as articles in journals.

Contact

You can contact the researcher on 0245135685/ 0200175146 with any further questions you may have.

Consent

I have full understanding of what I have read or have been read to me. I have received a copy of this form and have agreed to participate in the study.

Participant’s Signature……………………………………                   Date…………………………
Researcher’s Signature…………………………………………………           Date…………………………